NACCHO Submission to the Review of Pharmacy Regulation and Remuneration Interim Report

July 2017

NACCHO
National Aboriginal Community Controlled Health Organisation
Aboriginal health in Aboriginal hands
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TITLE:

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July 2017

National Community Controlled Health Organisation
Level 3, 221 London Circuit, CANBERRA ACT 2600
P.O. Box 5120, Braddon, ACT 2612

Contact:

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[redacted]

Acknowledgement:

Where the term “Aboriginal” or “Indigenous” is used in this submission it is written with respect to both Aboriginal peoples and Torres Strait Islanders.

Introduction

NACCHO welcomes the opportunity to provide further input into the Review of Pharmacy Regulation and Remuneration. Since the Review's Discussion Paper, a separate review commissioned by the Department of Health that specifically addresses 'Indigenous Pharmacy Programs' (IPP) has been completed. This review included appraisal of the CTG prescription measure, QUMAX, and the s100 RAAHS measure and Support Allowance. Over the previous 18 months, in the context of both reviews, NACCHO has conducted significant stakeholder consultation and literature review. Details of the consultation process, its findings and the 17 recommendations included to improve Indigenous Pharmacy Programs are discussed in the **attached document below (Attachment 1) titled: *NACCHO Submission to the Review of Indigenous Pharmacy Programs*.** We encourage the Panel to consider the recommendations within the attached document and their clear relationship to the Review of Pharmacy Regulation and Remuneration Interim Report and its relevant Options.

Very recent evidence shows that significant under-use of essential medicines persists within many Aboriginal and Torres Strait Islander communities across Australia today.[1] We welcome the repeated references from the Panel throughout the Interim Report for supporting and improving equity of access to medicines and pharmacy services. Supporting and enhancing medicines programs that address Aboriginal and Torres Strait Islander quality use of medicines (QUM) and access as referenced in the National Medicines Policy (NMP) is essential to improve equity and reduce the ongoing gap in health status for Aboriginal and Torres Strait Islander people compared with non-Indigenous Australians. NACCHO acknowledges the synergy and high-value relationships that exist between many community pharmacies and pharmacists with ACCHOs. These productive professional relationships have undoubtedly improved the health of many ACCHO clients. Therefore, NACCHO looks forward to continuing work with both pharmacy and stakeholder organisations, and the Department of Health to build relationships further and to enhance medicines policy and programs that deliver improved health outcomes.

NACCHO notes the Panel's clear reference for pharmacies to be *acceptable* according to World Health Organization standards.[2] Cultural responsiveness is a critical part of health service acceptability for many Aboriginal and Torres Strait Islander people.[3] Further embedding cultural competence into pharmacy programs must be an ongoing process. Similarly, program delivery and implementation should continue to engage with Aboriginal and Torres Strait Islander people and organisations as health settings evolve. NACCHO's attached Submission to the IPP Review has several recommendations for how this acceptability of pharmacy programs can be improved.

[1] https://www.pmc.gov.au/sites/default/files/publications/indigenous/hpf-2017/tier3/315.html
[2] D. Evans, J. Hsu & T. Boerma, Universal coverage and universal health access, Bulletin of the World Health Organization, vol. 91 (2013).
[3] http://www.aihw.gov.au/uploadedFiles/ClosingTheGap/Content/Publications/2013/ctgc-rs27.pdf

Practice Pharmacists Embedded in ACCHOs

NACCHO welcomes the Panel's support for pharmacists working within Aboriginal Health Services:

"the ability for an Aboriginal Health Service to employ pharmacists should be trialled".

NACCHO would like to highlight the support offered from peak bodies, jurisdictional government and national organisations within submissions to the Discussion Paper. These include:

1. The Society of Hospital Pharmacists Australia (SHPA)
2. The Pharmaceutical Society of Australia (PSA)
3. The Royal Australian College of General Practitioners (RACGP)
4. The Australian Medical Association (AMA)
5. Aboriginal Medical Services Alliance Northern Territory (AMSANT)
6. Northern Territory Government
7. National Rural Health Alliance

The details of how embedding pharmacists into ACCHOs could be achieved are included in the attached document *NACCHO Submission to the Review of Indigenous Pharmacy Programs*

Option 9-2: "Aboriginal Health Service Pharmacy Ownership and Operations"

"All levels of government should ensure that any existing rules that prevent an Aboriginal Health Service (AHS) from owning and operating a community pharmacy located at the AHS are removed. As a transition step, these changes should first be trialled in the Northern Territory, and governments should work together with any AHS that wishes to establish a community pharmacy."

NACCHO strongly supports the Panel's finding that "***The current inability of an AHS to operate a community pharmacy poses a significant risk to patient health in some rural and remote areas of Australia"*** and ***"The Panel also considers that the ability for an Aboriginal Health Service …to operate a pharmacy should be trialled".*** NACCHO would like to reinforce that our research and consultation shows that this recommendation can apply to AHSs in any geographical location. Since the Discussion Paper release, NACCHO has observed an amplification of interest regarding ACCHO-owned pharmacies, and has begun to build organisational networks to implement the Panel's recommendation.

Further Discussion

NACCHO endorses the Panel's recommendation that future CPA consultations should specifically include NACCHO. There are several CPA programs that frequently or even solely affect Aboriginal and Torres Strait Islander people, whose design and implementation involves no consultation with Aboriginal and Torres Strait Islander organisations. This includes s100 Support Allowance, Aboriginal and Torres Strait Islander Pharmacy Assistant Traineeship Scheme, Aboriginal and Torres Strait Islander Pharmacy Scholarship Scheme and Rural Support Programs.

NACCHO proposes several recommendations within *NACCHO Submission to the Review of Indigenous Pharmacy Programs* that address the Panel's transparency and accountability concerns.

Aboriginal and Torres Strait Islander people and organisations must be involved in leadership, design and implementation of all pharmacy programs that affect Aboriginal and Torres Strait Islander people, including all relevant pharmacy programs and in CPA negotiations.

Option 2.4 – Labelling:

"All PBS medicines provided to patients should be appropriately labelled and dispensed. Where there is a system in place that involves 'remote' dispensing or 'bulk supply' then this system will require appropriate monitoring to ensure the quality of medicine supply".

The paucity of health professionals working for Aboriginal and Torres Strait Islander people in regional and remote communities, including pharmacists, is alarming and well documented.[4] Accordingly, providing quality access to medicines, pharmacists and QUM for Aboriginal and Torres Strait Islander people in regional and remote Australia remains a challenge. Many guidelines, supported by state and territory legislation, aim to improve access to critical health services by giving culturally competent, often local, health practitioners the extended ability to service remote clients' needs. Various training programs and the local legislation supports this activity. This is a critical equity measure that ensures patients who may otherwise have no or little access to healthcare can receive essential health services within their local community setting. There is known value in holistic health services' being in close proximity to Aboriginal and Torres Strait Islander communities. [5] The value pertains to both health outcomes and to Aboriginal and Torres Strait Islander workforce and service capacity for these communities. The cultural and community knowledge of local Aboriginal and Torres Strait Islander people is also immensely valuable to engage clients with their healthcare.[6] Therefore, it is critical that any 'monitoring to ensure the quality of medicine supply' for regional and remote regions must respect the cultural and geographical elements of the care setting and capacity of the services involved.

NACCHO recommends that the solution for this perceived problem is to build knowledge and capacity within the local, community-controlled and culturally responsive health services to identify labelling or dispensing issues against the appropriate standards and legislation. ACCHOs should determine how individual challenges can be addressed in the context of their services' broader systems, including Continuing Quality Improvement (CQI) systems. Supporting the involvement of pharmacists and community pharmacies in identifying and addressing clinic labelling and dispensing concerns can be implemented by expanding the established Aboriginal and Torres Strait Islander QUM programs, such as QUMAX. Details of NACCHO's recommendations are outlined in *NACCHO Submission to the Review of Indigenous Pharmacy Programs.* The complexity of national and jurisdictional regulations and guidelines for in-clinic medicines supply activities supports this needs-based, community directed approach, as compared to further regulatory measures which are likely to be ineffective and confounding.

Please refer to the attached document below (Attachment 1) titled: *NACCHO Submission to the Review of Indigenous Pharmacy Programs*.

[4] http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129557662
[5] http://www.aihw.gov.au/uploadedFiles/ClosingTheGap/Content/Publications/2013/ctgc-rs27.pdf
[6] What Indigenous Australian clients value about primary health care: a systematic review of qualitative evidence, 2017, Gomersall, JS et al. Aus NZ Journal of Pub Health.

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Attachment 1:

NACCHO Submission to the Review of Indigenous Pharmacy Programs

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Acknowledgements:

This submission has been informed by NACCHO engagement with a range of key informants within the Aboriginal Community Controlled Health Sector, community Pharmacists, clinicians and practice managers. NACCHO acknowledges the participation engagement and assistance of these individuals and the agencies that they represent.

Where the term “Aboriginal” or Indigenous is used in this submission it is written with respect to both Aboriginal peoples and Torres Strait Islanders.

Executive Summary

The current situation

Disparities in the health and social disadvantage between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians are confronting. Aboriginal and Torres Strait Islander people have two-to-three times higher levels of illness than non-Indigenous Australians and are known to experience a significantly higher burden of chronic disease. Despite the high burden of chronic disease, under-use of medicines amongst Aboriginal and Torres Strait Islander people is a glaring reality. Recent figures have shown that total expenditure on pharmaceuticals per Indigenous person was around 44% of the amount spent per non-Indigenous person ($369 compared with $832). Social circumstances, cultural deficiencies in health services and systems mean Aboriginal people often suffer challenges in medicine management and may have poorer adherence to treatment compared with non-Indigenous Australians. [1]

Current pharmacy programs for Aboriginal and Torres Strait Islander people may be referred to as Indigenous Pharmacy Programs (IPPs), and include Closing the Gap (CTG) PBS Co-payment Measure, Section 100 Remote Area Aboriginal Health Service measure (s100) and Quality Use of Medicines Torres Strait Maximised for Aboriginal and Islander People (QUMAX). Government commissioned and peer-reviewed literature has repeatedly shown these programs to be effective in addressing health disparities, improving medicines access, and they are productive programs for both users and administrators.

Despite some known challenges associated with how the programs work together, general program satisfaction and effectiveness has recently been corroborated by National Aboriginal Community Controlled Health Organisation's (NACCHO) extensive consultation with Member Services and stakeholders. In many cases, Aboriginal Community Controlled Health Organisations (ACCHOs) are recognising the considerable value pharmacy services provide to their communities, to the extent that some now supplement funded pharmacy programs with their own organisational funds to maximise the outcomes.

There is strong program knowledge capital that has grown amongst service-providers and government as the programs have developed. To continue progress toward Closing the Gap, it is imperative governments and stakeholders support and build on both the goodwill and successful allocation of resources into Indigenous Pharmacy Programs (IPPs). Any further research or assessment of pharmacy programs' effectiveness must involve flexible approaches that respect Aboriginal and Torres Strait Islander communities' existing practices and health priorities, and their Continuing Quality Improvement (CQI) systems and data ownership.

During the last 12 months NACCHO has coordinated several consultation processes, involving Member Services and a broad range of stakeholders across all states and territories, to garner input on medicines and pharmacy services delivered to ACCHOs. This consultation included multiple teleconferences, workshops, national online Member Services questionnaire, literature review, expert consultation and more and has been punctuated by the Pharmacy Regulation and Remuneration Review and now The Review of Indigenous Pharmacy Programs. NACCHO has dedicated a policy team to respond to this review, including staff members with high level technical, operational and policy expertise.

Results from NACCHO's consultation strongly support common finding and recommendations in previous reviews and submissions. This submission reinforces these recommendations and builds on existing solutions to bolster a clear way forward.

Enhancements to current programs

Potential enhancements to Indigenous Pharmacy Programs (IPPs) are now well documented. This includes;

- expanding who can write CTG prescriptions to include non-Practice Incentive Payment GP referred specialists and hospital prescribers
- linking medicines subsidy eligibility to a client and not a location (including removal of the eligibility link to Practice Incentive Payments)
- pharmacists having the ability to annotate scripts as CTG
- improving how mobile clients can access medicines across geographical and care-related settings (e.g. CTG script writing for travelling remote ACCHO clients) and
- enhancing Quality Use of Medicines (QUM) programs, especially for those in remote areas.

These strategies address the known gaps, while they appear small, can affect the most vulnerable and high-acuity clients. For this reason, there is considerable value in the targeted enhancements to programs recommended within this submission. The changes above are also likely to significantly improve the patient journey and make the system simpler for health professionals and administrators.

High value systems changes and innovation

NACCHO's priorities involve holistic and integrated care, community control, and improved community access and engagement. This care model has been clinically and economically validated. In addition to minor enhancements, there are several suggested systemic solutions that could further integrate and improve pharmacy services and goods delivered to Aboriginal and Torres Strait Islander people within ACCHOs' models of care. Despite being systemic changes, in many cases these changes could be implemented very easily.

While the current IPPs have greatly improved medicines access and PBS uptake, literature suggests that more could be done to address some barriers to access and engagement with pharmacy services. While they may be effective in isolation, more work on how programs work together to provide a seamless patient journey is critical. There is strong support from Members and many external stakeholders for developing an integrated practice pharmacist model to be embedded in ACCHOs to address these issues. This model of care can improve clinical care and cultural safety, transitions of care, staff medicines knowledge and add great value to the health system in which ACCHOs operate. Practice pharmacists are entirely synergistic to community pharmacy activities, they can ensure that the medicines supply chain is effective and efficient, and can improve the effectiveness of IPPs. Incentivising practice pharmacist activities in remote areas, including funding positions for pharmacists to relocate to regional or remote locations, will also address the known pharmacy services maldistribution between urban and remote settings.

Other programs suggested by Members include regionally shared Quality Use of Medicines pharmacists, whose services may be particularly valuable when rural pharmacist supply is low or

health service size is inadequate for a full or part-time practice pharmacist. The option to have a pharmacy owned and controlled by an ACCHO would be the ultimate solution to addressing known gaps in pharmacy services for some organisations. The model allows services the most flexibility to tailor the range of existing 6CPA programs and others to their communities' needs.

Conclusion

Given how well-established current programs are, NACCHO proposes the need for both incremental program enhancements targeting current known gaps in combination with systemic changes or new programs outlined by literature and NACCHO's broad consultation. There is significant evidence and precedent supporting NACCHOs recommendations, and NACCHO is confident these will produce improved health outcomes and provide high value solutions for all parties.

Recommendations

Overarching recommendations

1. Government continues to support and enhance allocation of necessary resources towards Indigenous Pharmacy Programs and that NACCHO is actively involved in the design and delivery each of the programs.
2. Adequate funding or incentives are needed in new and existing programs to ensure uptake and viability, and thus improve equity.
3. Any future assessment of IPP effectiveness must have a flexible approach and respect Aboriginal and Torres Strait Islander communities' models of care, data ownership, existing CQI systems and health priorities.

Program enhancements to be implemented now

4. CTG annotation is expanded to include:
    - 4.1. Allowing **all** hospital prescribers to issue patients with CTG prescriptions and allow hospital pharmacies to dispense CTG scripts for all CTG-eligible clients
    - 4.2. Allowing **all** specialists to issue patients with CTG prescriptions for all CTG-eligible clients
    - 4.3. Granting dispensing pharmacists the ability to annotate scripts if patients are known to be enrolled in CTG
    - 4.4. Allowing all ACCHOs and Aboriginal and Torres Strait Islander Medical Services to be able to write CTG scripts regardless of location (including s100 RAAHS services)
5. De-linking CTG from Practice Incentives Payment - Indigenous Health Incentive

6. Link CTG eligibility to the client's Medicare card and removing all geographical constraints of CTG

7. A Quality Use of Medicines resource package is developed for all ACCHOs to include;
    - 7.1. Cultural competence framework to help ACCHOs deliver cultural competence training and education to their local pharmacies
    - 7.2. Templates for ACCHOs to assess their pharmacy needs, including tender and commissioning for pharmacy services
    - 7.3. Resource explaining current pharmacy services and programs available to ACCHOs
    - 7.4. Communication resource e.g. explaining how workflow and operations can be improved between organisations, such as use of My Health Record (MHR)

7.5. Other relevant guidelines e.g. The *Guide to providing pharmacy services to Aboriginal and Torres Strait Islander People* PSA 2014

7.6. The resource package is disseminated to all ACCHOs, other Aboriginal and Torres Strait Islander Health Services, and community pharmacies to support the development of ACCHO QUM programs.

8. Additional resources are made available to enable expansion of QUMAX and s100 to include:

8.1. Employment of a QUM Aboriginal Health Worker (AHW) with in the ACCHO to work closely with patients and their families, local community pharmacists and other health providers.

9. NACCHO establishes and supports a national consultative body involving all relevant stakeholders. This group will provide guidance and commission some resources with the aim to improve pharmacy services and programs for Aboriginal and Torre Strait Islander people.

10. The Integrated Team Care program (ITC - formerly CCSS) national guidelines is amended so that ITC does not offset QUMAX funds

11. NACCHO's Members and NACCHO must have the opportunity to provide input and feedback on developments in the s100 dispensing fee. s100 ACCHOs must have direct access to their full s100 dispensing data.

High value systems changes and innovation

Despite being systemic changes, in many cases the changes below have very low implementation burden.

12. Build framework and funding platform that facilitates ACCHOs to employ practice pharmacists

12.1. A relevant and practical framework is developed to guide the development of expanded roles of practice pharmacists within the context of the Aboriginal community controlled primary health care setting.

12.2. Enhanced resources are allocated within or outside of existing IPPs to support ACCHO capacity to employ practice pharmacists. Funding models for an ACCHO practice pharmacist could include:

- Incentives similar to the Practice Nurse Incentive Payment (PNIP) scheme
- Fee-for-service billing arrangement such as MBS claiming for medicines management
- A 6CPA funded program trialled under the Pharmacy Trails Program.
- A combination of the above

13. Expand quality use of medicines programs to improve known problems associated with the s100 Support Allowance program including low ACCHO-pharmacy engagement, poor accountability and medicines wastage. This may involve amalgamating the two programs and can be done in the following ways:

13.1. All ACCHOs across Australia, including s100 and remote ACCHOs, have access to the core elements of QUMAX (such as community-controlled resource allocation and DAA subsidy).

13.2. All ACCHOs across Australia may access a provision similar to s100 Support Allowance to assist ACCHOs collaborating with pharmacies in planning relating to non-QUM services, such as imprest stock management or medicines room legal compliance.

14. A model for regionally shared pharmacy services is developed and resourced to support smaller ACCHOs accessing QUM services and resources.

15. Any review of s100 service eligibility criteria will include broad consultation with Aboriginal and Torres Strait Islander communities and organisations across all geographical regions of Australia, and must consider the following;

15.1 how many non-remote, non-s100 eligible ACCHO clients experience significant barriers to medicines access (often necessitating large, expensive imprest systems in ACCHOs to manage this

15.2 inclusion of enhancements that build on ACCHO-community pharmacy engagement and aims to improve the uptake of community pharmacy services to ACCHO clients, in complement to imprest supply.

16. ACCHOs in all states and territories are granted the legal capacity to own, operate and control a section 90 pharmacy if there is a need and capability identified by the community. This would be implemented in combination with pharmacy business support and resources.

17. If a unified medicines subsidy scheme were to be considered that combines s100 and CTG, NACCHO recommends a round table approach with all relevant stakeholders.

This document separates discussion and subsequent recommendations into three parts:

1) The current situation and overarching recommendations
2) High value systems changes and innovation
3) Program enhancements to be implemented now

Contents

Terms and acronyms

6CPA – The Sixth Community Pharmacy Agreement

ACCHO – Aboriginal Community Controlled Health Organisation

AHP – Aboriginal Health Practitioner

AHS – Aboriginal Health Service

AHW – Aboriginal Health Worker

ITC – Integrated Team Care program (Formerly Care Coordination and Supplementary Services or CCSS)

CTG – Closing the Gap PBS Prescription Co-payment Measure

DAA – Dose Administration Aid (e.g. Webster pack, blister pack)

GP – General Practitioner

HMR – Home Medicine Review (a structured, co-funded through MBS and 6CPA program where a credentialed pharmacist reviews a client's medicines within their home)

IPP – An Australian Government Indigenous Pharmacy Program. This includes 4 programs: Closing the Gap (CTG) Prescription Co-payment Measure, The section 100 Remote Area Aboriginal Health Service PBS supply arrangements, s100 Support Allowance and Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander peoples program (QUMAX).

MedsCheck – MedsCheck (or Diabetes Meds Check) is one of the 6CPA in-pharmacy medication management services

Members – Member Services of NACCHO

MMR – Medication Management Review. An umbrella term used to describe pharmacist-led medication management services including HMRs, MedsChecks and Residential Medication Management Reviews.

NACCHO – National Aboriginal Community Controlled Health Organisation Ltd

NHA – National Health Act 1953 (the act that governs PBS supply and includes section 100 remote Aboriginal Health arrangements)

nKPIs – National Key Performance Indicators for Aboriginal and Torres Strait Islander People

NMP – National Medicines Policy

s100 or s100 RAAHS – The section 100 Remote Area Aboriginal Health Service PBS supply arrangements of the National Health Act 1953

PBS – Pharmaceutical Benefits Scheme

PSA – The Pharmaceutical Society of Australia (peak national pharmacy body, across sectors)

QUM – Quality Use of Medicines

QUMAX – Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander peoples. This program is one in a suite of 6CPA programs that aim to improve quality use of medicines and provide culturally appropriate services for Aboriginal and Torres Strait Islander peoples.

QUMP – Quality Use of Medicines Pharmacist

RAAHS – Remote Area Aboriginal Health Service

RN – Registered Nurse

s100 – The section 100 Remote Area Aboriginal Health Service PBS supply arrangements

s100 Support Allowance – The S100 Pharmacy Support Allowance: an allowance for the provision of a range of Quality Use of Medicine (QUM) services to patients in remote area Aboriginal Health Services (AHSs) participating in the S100 supply arrangements.

The Department – Australian Government Department of Health

The Government – The Australian Government

The Guild or PGoA – The Pharmacy Guild of Australia

The Review – The Review of Indigenous Pharmacy Programs 2017

About NACCHO and its Member Services

Based in Canberra, the National Aboriginal Community Controlled Health Organisation (NACCHO) is the national peak Aboriginal health body. NACCHO represents the interests of its Membership, which is comprised of over 140 Aboriginal Community Controlled Health Organisations (ACCHOs), to the federal level of government its bureaucracy, other government bodies and health organisations.

> *It is important to highlight and acknowledge the different understandings of health between a western context and an Aboriginal cultural context. The western understanding of health is an absence of disease; someone is healthy if they do not have a disease, or illness. The Aboriginal understanding of health is holistic and includes land, the physical body, the mind, clan, relationships, and lore. Health, in an Aboriginal cultural context, is the social, emotional and cultural wellbeing of the whole community, not just the individual.*

As the voice of its Members, NACCHO is the national authority on Aboriginal comprehensive primary health care. NACCHO's authority comes from over 40 year's engagement with health care services that have been established and operated by local Aboriginal communities, through locally elected Boards of Management, to deliver holistic, comprehensive and culturally appropriate health care.

Directed by a Board of Management, with representation sought from among its Members to embody community control, NACCHO has been pivotal in improving the circumstances for Aboriginal and Torres Strait Islander people. This has been achieved by working closely with its Members and affiliate State and Territory peak Aboriginal Community Controlled Health bodies to agree upon, then work to address, a national agenda for Aboriginal and Torres Strait Islander health.

NACCHO advocates to government in terms of evidence-supported, community-developed responses and solutions to social, economic and political conditions that prevail in many Aboriginal communities. Conditions that affect the social, emotional, spiritual and physical wellbeing of Aboriginal and Torres Strait Islander peoples, their families and communities. NACCHO continues to be the living embodiment of the aspirations of Aboriginal communities and their struggle for self-determination.

About the ACCHO sector

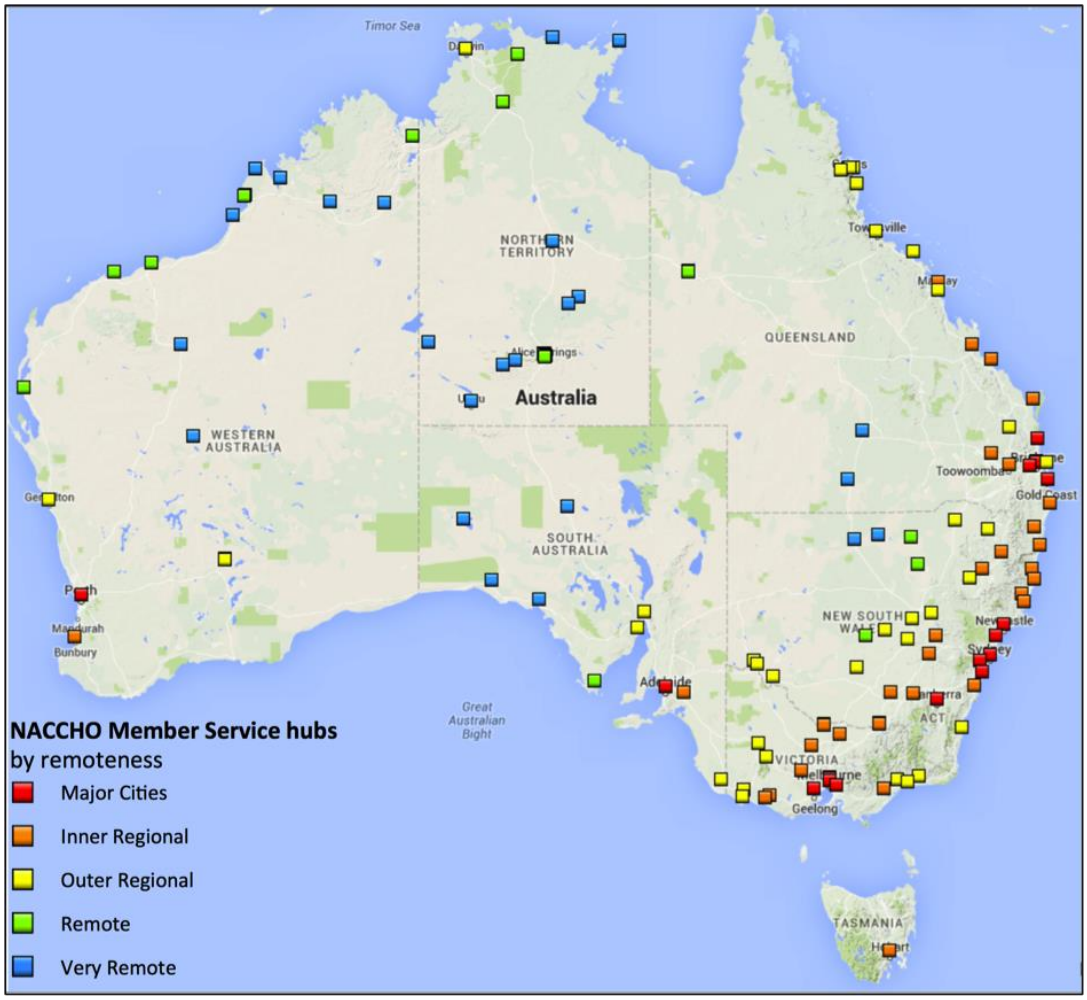
The first ACCHOs were established in the early 1970s by Aboriginal and Torres Strait Islander peoples, in response to inadequate and culturally inappropriate mainstream health care services. ACCHOs now lead the way in innovative, high-quality, multidisciplinary and culturally-safe models of holistic primary health care delivery, responsive to local community needs.

These models of primary health care recognise important social, emotional, spiritual, physical and cultural needs particular to local Aboriginal or Torres Strait Islander individuals and their community. This is done by providing locally specific health promotion, chronic diseases prevention and management. At the same time supporting the process of personal self-determination through the complex, multi-layered health management system. Main stream primary health care services, public

and private, are yet to effectively reproduce the holistic approach to health care delivery provided by ACCHOs across the country.

ACCHOs operate in urban, regional, remote and very remote Australia. They range from large multi-functional services employing several medical professionals and health workers providing a wide range of services in urban and regional centres, to small services providing the bulk of comprehensive primary care services, often with a preventative, health-education focus. ACCHOs form a network, but each is autonomous and independent both of one another and of government.

Figure one: Map of NACCHO Member Services



Section 1 – The current situation and overarching recommendations

Introduction

NACCHO was advised late 2016 that Urbis has been engaged by the Commonwealth Department of Health (the Department) to undertake the review of Indigenous Pharmacy Programs (the Review). In January 2017 NACCHO met with Urbis to discuss the purpose and objective, and the intended process. Urbis provided NACCHO with a document called the Objective Project Summary which described the Review objective;

'Provide advice to the Department on improvements to the design and administration of the Programs to maximise access and quality use of PBS medicines.
Specifically, the review will assess the effectiveness of the delivery of programs, individually as well as where access and pharmacy support programs operate in parallel'

The final analysis and report is reported to be due May/June 2017.

NACCHO appreciates the opportunity to make a submission in response to the Review of Indigenous Pharmacy Programs (IPP). The programs under this review are;

- Closing the Gap PBS Co-payment Measure
- Section 100 RAAHS (s100) and
- Section 100 Support Allowance, and
- Quality Use of Medicines Torres Strait Maximised for Aboriginal and Islander People (QUMAX).

Aboriginal and Torres Strait Islander peoples face significant barriers to efficient use of PBS medicines including access, financial considerations, cultural and geographical factors. The programs currently under review aim to support both access to medicines and Quality use of Medicines (QUM) for Aboriginal and Torres Strait Islander people.

Background to the programs

Indigenous Pharmacy Programs relate to two core medicines concepts, both referenced in the Australian National Medicines Policy (NMP) 2000. [2] These are:

1. Quality Use of Medicines (QUM)
2. Improving access to medicines

QUM is well defined in the National Medicines Policy (NMP) and relates to clinical care; specifically, to the appropriate, safe and effective use of medicines to clients. Within the National Medicines Policy, the term 'access' relates to cost of medications and timeliness of their provision.

The IPP value proposition:

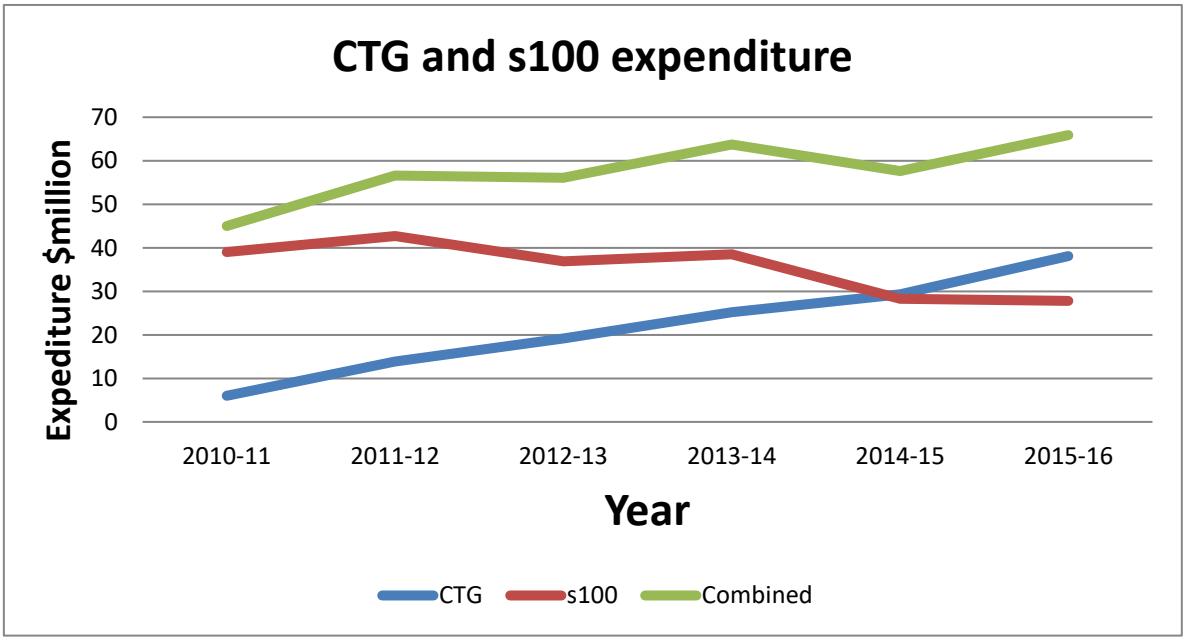
Below is a basic summary of costs, outcomes and eligibility for each IPP:

Table 1 - IPP costs and outcomes

Program/ measure	Annual cost indication (approx.)	Primary outcomes	Eligibility
CTG	$38 million/year	• Improved access by reducing financial barrier • ~4 million PBS items supplied per year	With or at risk of chronic disease I-PIP practice
s100	$27 million/year	• Improved access by reducing financial and geographical barriers • 1.1 million PBS items supplied per year	Anyone attending remote or very remote Aboriginal and Torres Strait Islander health service (RAAHS)
QUMAX	$3 million/year	• Improved QUM	Non-remote ACCHOs Patients with or at risk of chronic disease
s100 Support	$4 million/year	• Improved QUM and QUM administration	s100 ACCHO and non-ACCHOs

While expansion of medicines subsidy schemes is slowly growing to catch up to the identified need, Federal investment in pharmacy services and QUM for Aboriginal and Torres Strait Islander people (i.e. QUMAX and s100 Support Allowance) has not increased at the same rate as medicines subsidy and only attracts around 10% of the funds allocated to provision of pharmaceutical goods. National spending to improve medicines access focusses heavily on reducing financial barriers, other known barriers to access, such as cultural safety are not addressed in a commensurate way.

Table 2 - Indigenous medicines subsidy scheme spending



The combined IPP spending still only accounts for less than 1% of total PBS spending within Australia. This proportion has been relatively static at around 0.8% for the last 4 years.

Table 3 - Indigenous medicines subsidy scheme spending compared with general PBS ($ in millions)

Year	CTG	s100	Combined	PBS Total	% of total PBS
2010-11	$ 6	$ 39	$ 45	$ 7,323	0.61%
2011-12	$ 14	$ 43	$ 57	$ 7,528	0.75%
2012-13	$ 19	$ 37	$ 56	$ 7,088	0.79%
2013-14	$ 25	$ 39	$ 64	$ 7,317	0.87%
2014-15	$ 29	$ 28	$ 58	$ 7,096	0.81%
2015-16	$ 38	$ 28	$ 66	$ 7,949	0.83%

Current Aboriginal and Torres Strait Islander pharmacy programs

Current pharmacy programs for Aboriginal and Torres Strait Islander people have been repeatedly shown by government commissioned and peer-reviewed literature to be effective and acceptable for both users and administrators. [3,4,5] This has recently been corroborated by NACCHO's extensive Member and stakeholder consultation relating to both the Indigenous Pharmacy Programs and the Review Pharmacy Remuneration and Regulation Review. For example, in their submissions to the Review Pharmacy Remuneration and Regulation Review, the Australian Medical Association (AMA) and the Australian Healthcare & Hospitals Association (AHHA) call for resources put towards Aboriginal and Torres Strait Islander pharmacy programs to be expanded.

There is a strong program knowledge capital that has grown amongst service-providers and government as the programs have developed. In many cases, ACCHOs are recognising the value of pharmacy services and supplementing funded pharmacy programs with their own organisational funds. This is a true endorsement of the need for, and value of, pharmacy services, but also shows that more can be done. Therefore, to continue to move towards closing the gap, it is imperative that governments and stakeholders continue to support and build on both the goodwill and allocation of necessary resources towards current Indigenous Pharmacy Programs.

The QUMAX Program is a collaboration between NACCHO and the Pharmacy Guild of Australia, funded by the Commonwealth Department of Health under the Community Pharmacy Agreement. Much of QUMAX's success is attributable to NACCHO involvement in the administration of the program since 2008. Unfortunately, NACCHO's involvement in policy development and implementation of the other three Indigenous Pharmacy Programs under review has been minimal, despite NACCHO members and their clients the most likely to be impacted any change associated with the Review.

Recommendation:

Government continues to support and enhance allocation of necessary resources towards Indigenous Pharmacy Programs and that NACCHO is actively involved in the design and delivery each of the programs.

Case Study: The success of Quality use of medicines maximised for Aboriginal and Torres Strait Islander people program (QUMAX)

The QUMAX program is a collaboration between NACCHO and the Pharmacy Guild of Australia, funded by the Commonwealth Department of Health under the Community Pharmacy Agreement. NACCHO has been involved in the administration of the QUMAX program since 2008.

QUMAX is a proven program which optimises the quality use of medicines for Aboriginal and Torres Strait Islander patients, delivered by ACCHOs and community pharmacies QUMAX has consistently received strong support from both ACCHOs and community pharmacies. NACCHO's consultation and literature review has shown that QUMAX has improved health outputs and outcomes for Aboriginal and Torres Strait Islander peoples.

The 2011 Evaluation of the QUMAX Program by Urbis in 2011[6] reported key outcomes including:

- Successful in trialling a number of mechanisms to address known barriers to accessing PBS medication in non-remote Aboriginal and Torres Strait Islander communities
- Increased access to PBS medicines
- Increase in regularity and quality of contact between ACCHOs and their clients
- Increased patient understanding and self-management of their condition
- Improvement in patient health such as lowered HbA1c, reduced blood pressure, blood glucose and cholesterol.

The 2011 Urbis evaluation report noted key success factors were found in Program structure and design implementation at the Program management and local level. Key success factors included:

- Strong effective governance and advisory structure, and a sound set of business rules and guidelines
- Well managed by the QUMAX program managers at NACCHO and the Guild
- Achieved almost universal participation by eligible ACCHOs
- Flexibility with in the program guidelines to enable ACCHOs to focus on local issues and needs
- The inclusion of regional support mechanisms via Quality Use of Medicines Pharmacists (QUMPS) and NACCHO Affiliates
- Regular contact between ACCHOs and QUMPs

The recommendations from the Urbis evaluation were:

1. Continuation of the QUMAX Program working in parallel the CTG co-payment measure
2. Provision of DAAs provided under QUMAX to continue
3. Provision of transport under QUMAX to continue
4. Exploring ways to make HMRs more useful to ACCHOs in the management of chronic disease (the reported noted anecdotally the QUMAX program was associated with an increased uptake in HMRs)
5. Development of models appropriate to the local context should be pursued
6. The QUM, administrative and practical support offered ACCHOs by NACCHO and the Guild program managers and QUMPS continue
7. The process of flexibility to develop work plans responsive to local needs to focus on QUM rather than administration
8. The QUMAX partnership/ governance model could be adapted to a range of health program for Aboriginal and Torres Strait Islander peoples.
9. Future program funds should support the development and maintenance of an online information management system. Funds should also be allocated to regular national and/or state and territory conferences and workshops.

About s100 Remote Area Aboriginal Health Service (RAAHS) measure

The s100 RAAHS scheme traditionally allows only remote or very remote Aboriginal Health Services and ACCHOs to obtain bulk supplies of medications through a community pharmacy (i.e. not for specific clients) to the clinic to store and issue within the operations of their practice. A new provision commenced in January 2017 subsidises pharmacies to dispense medicines to individual clients, this is often done through the provision of DAAs to ACCHOs and AMSs. Once the ACCHO receives the DAAs,

these are supplied to clients through the normal operations of the health services. The medicines supplied from the clinic are free to all clients of the AHS or ACCHO, however remote services' DAAs are not subsidised through any IPP.

Where medicines are not dispensed by the pharmacy, the medication is ordered on a periodical basis and supplied in bulk. Medicines are then issued in original packaging or divided into a smaller supply by other clinical staff such as AHWs, RNs and GPs. While these practitioners may not be formally trained in dispensing or counselling at a level of a pharmacist, immediate medicines access on site is essential and this service can be delivered in a culturally responsive way.

Closing the Gap PBS Prescription Co-payment (CTG)

The CTG measure's effectiveness in improving medicines access for Aboriginal and Torres Strait Islander people is unquestionable and displayed in public Department of Health data. However, limitations have been clearly identified, especially in how the program interacts with other IPPs. NACCHO and the Pharmacy Guild of Australia have signed a Joint Position Paper that outlines some key areas that would improve access to medicines and pharmacy services and pharmacy programs within the 6CPA. Issues that have been corroborated by NACCHOs recent consultation include:

1. Interaction between programs and mobility of people living in remote areas
2. Changes to CTG eligibility status and requirement of annotation on the prescription
3. Coverage of medicines under the CTG co-payment measure
4. Improving Quality Use of medicines (QUM) support services
5. Promotion of the CTG co-payment measure

Ongoing medicines issues identified

Aboriginal and Torres Strait Islander people have two-to-three times higher levels of illness than non-Indigenous Australians[7] and are known to experience a significantly higher burden of chronic disease.[8] Despite the high burden of chronic disease, under-use of medicines amongst Aboriginal and Torres Strait Islander people persists.[9] The rate of potentially avoidable hospitalisations for Aboriginal and Torres Strait Islander people is almost five times the rate for other Australians, with over half of these related to chronic conditions.[10]

Aboriginal and Torres Strait Islander people's access to primary health services remains disproportionately low particularly when considering their higher burden of chronic disease.[11] PBS medicines continue to be underutilised compared with non-Indigenous Australians.[12,13] Quality Use of Medicines services are accessed at lower rate, a problem often compounded by more complex medicine regimens and more co-morbidities seen in Aboriginal and Torres Strait Islander patients.[14]

Medicines wastage

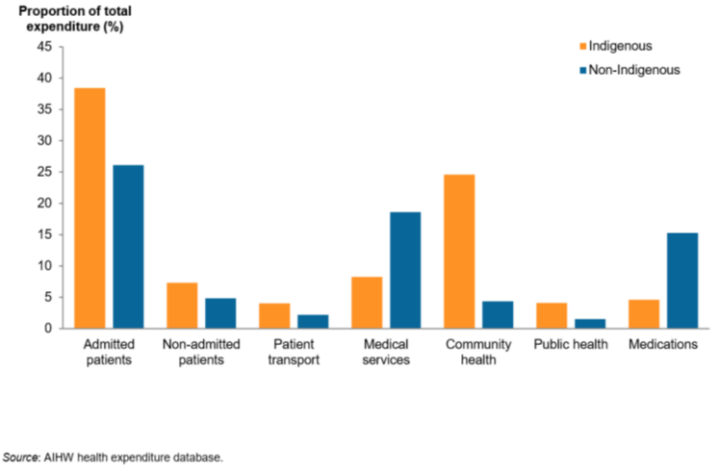
There are some anecdotal reports of medicines wastage related to IPPs. For example, this may occur when DAAs are not collected by clients and accrue at a community pharmacy. While there are some anecdotal reports of this occurring in a small number of remote sites, NACCHO emphasises that literature and consultation has not shown this problem to be widespread or significant, especially in non-remote ACCHOs which represent the majority of NACCHO's Members. Moreover, systemic methods to address perceived 'wastage' may in fact create further barriers to medicines access and thus produce poorer outcomes. Any approach to address wastage should acknowledge ACCHOs' priorities and practices to approach this issue on a local level where need is identified. This may involve developing communication systems between pharmacies and ACCHOs to report unused medicines, which could be part of the Quality Use of Medicines resource package discussed in this Submission.

Gap in access and utilisation of medications

Together with changes to lifestyle factors, long term medicine treatment is usually needed to prevent or reduce disease progression and thereby mitigate outcomes of ill health. Poor adherence to prescribed medicines is well documented and associated with adverse health outcomes in all population groups.[15] Social circumstances, deficiencies in health services and systems mean Aboriginal people often suffer even greater challenges in medicine management than non-Indigenous Australians. Social and emotional wellbeing issues may deeply pervade the lives of many Aboriginal people and may diminish the value that individuals place upon medicines, and the potential of these medicines to improve their quality of life.[16]

"Australia's mainstream medical model focuses on compliance with medical advice and often ignores the complex historical and sociocultural influences that shape patients' responses to their health and health care."[17]

Disparities in health literacy have been identified for Aboriginal and Torres Strait Islander clients, [18] and the cultural appropriateness of some pharmacies has been identified as a problem across Australia. [19,20] Barriers to accessing medicines for remote Aboriginal and Torres Strait Islander people may include financial and geographic constraints, failed patient-clinician interactions, poor healthcare delivery systems and complex therapeutic medication regimens.[21] Other barriers include economic hardship or poverty, racism, dispossession, the stigma associated with a diagnosis of chronic disease, educational disadvantage, shared crowded households, increased patient mobility, and inadequate health professional support.[22,23]



Source: AIHW health expenditure database.

Table 4 - Contributions of selected areas to health expenditure for Indigenous and non-Indigenous Australians, 2010-2011

Recent figures have shown that total expenditure on pharmaceuticals per Indigenous person was around 44% of the amount spent per non-Indigenous person ($369 compared with $832).[24] In 2010–11, 19% of Aboriginal and Torres Strait Islander people had prescriptions that they did not fill in the last 12 months. For 34% of these clients, cost was the reason for not filling the prescription. Those aged 45–54 were more likely than those in younger or older age groups to not have their prescription filled because of the cost (44% compared with 30%–35%).[25]

Research conducted in 2007 included semi-structured, face-to-face, in-depth interviews with 27 community pharmacists in NSW working with Aboriginal and Torres Strait Islander clients. Responses included 'lack of money' for clients to fill prescriptions was an issue.

"they might have three or four prescriptions to take, but may only take two because of cost…" [26]

While very recent evidence suggests these numbers may be getting better, [27]it is clear that Aboriginal and Torres Strait Islander uptake of medicines could still be improved significantly. In addition to access and affordability, cultural responsiveness of some pharmacy services also needs to be addressed. This is discussed in sections below.

Pharmacists workforce

Poor supply of pharmacy services and pharmacists to remote and regional areas of Australia is well documented. [28,29] For Aboriginal and Torres Strait Islander peoples this is exacerbated by higher rates of chronic conditions and comorbidities, resulting in the need for more complex medicine needs compared to the general population. [30] The deleterious impact the pharmacist deficit has had on client care and ACCHO service delivery has been noted by NACCHO's Members and other stakeholders for some years.

The need for enhanced pharmacy services in regional and remote areas has been reinforced clearly during NACCHOs recent interactions with Members, Affiliates and stakeholders. Many are fearful of participating in pharmacy programs and services for the difficulty in finding pharmacists, especially those with the appropriate skills and knowledge for this setting. There are currently no incentives or

initiatives that have had a significant impact on this problem, including the inadequate funds available through s100 Support Allowance.

Conclusion

While current IPPs have provided welcomed and quantifiable improvements in QUM and medicines access for Aboriginal and Torres Strait Islander people. It is clear ongoing support of programs addressing Aboriginal and Torres Strait Islander pharmacy needs must be enhanced if any progress towards Closing the Gap is to continue.

In the context of ongoing medicines usage and health disparities cited above, NACCHO and other stakeholders have provided detailed feedback and evidence-based recommendations to improve IPPs and how they may work together. These recommendations extend back for some years. For example, significant stakeholder feedback suggests programs, while effective in isolation, in combination they are fragmented and confusing for both consumers and health services.

"We all have these different schemes, it's hard for anyone working within the system to understand it, let alone the patient: QUMAX funding, CTG, Section 100 funding…and the poor patient's moving around trying to navigate these things, they have no idea why their medicine's subsidised and sometimes it isn't."[31]

(Australian Journal of Pharmacy: Lindy Swain, Pharmacist and Academic, specialising in Aboriginal and Torres Strait Islander health)

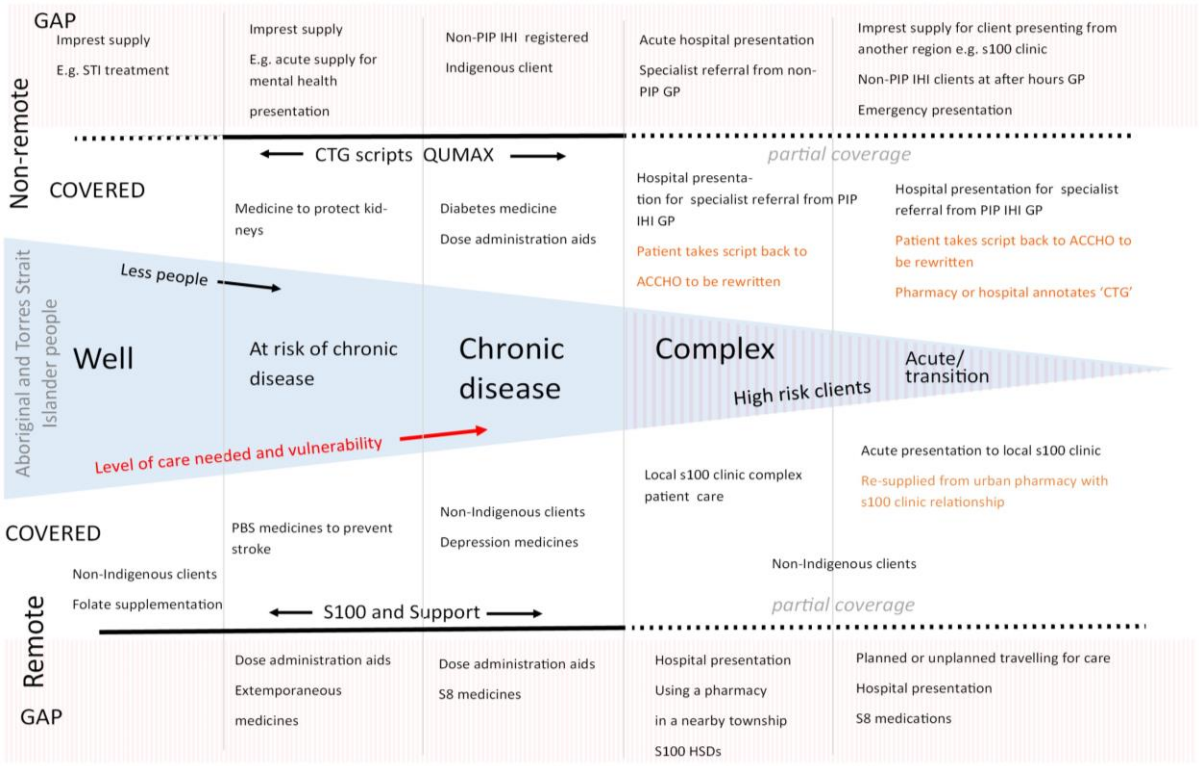


Figure 1 - Current pharmacy programs for remote and non-remote Aboriginal and Torres Strait Islander patients

Above is a graphical illustration of the current IPPs. This system is quite complex and separates remote from non-remote clients. The majority of clients accessing care who are at risk or have a chronic disease often receive medicines subsidy and QUM programs effectively. However, note that the two distinct systems divided by geography are complex and have a number of gaps (red section) and 'workarounds' (in orange). The service gaps and the system's complexity confound the patient journey, impede workflow and disparately affect the most vulnerable and high-risk clients. Eligibility criteria are not consistent between locations, which worsens inequity.

NACCHO's Consultation and Response Process

The Review of Indigenous Pharmacy Programs and any resulting changes will impact on ACCHOs who participate in, and whose clients benefit from, the services offered by these programs. NACCHO's huge Member base will be directly affected by any changes resulting from the review, therefore NACCHO's consultation has involved a broad range of stakeholders and has included participants from every state and territory.

NACCHO's response aims to build on the evidence and recommendations provided in NACCHO's recent response to the Pharmacy Regulation and Remuneration Review. NACCHO's priorities involve holistic and integrated care, community control, and improved community access and engagement, all of which have been clinically and economically validated in the ACCHO sector. [32]

NACCHO has dedicated a policy team to responding to the IPP review and a comprehensive consultation and a response timeline was mapped out against key milestones. NACCHO' response draws from its large national network and capacity to engage Member Services and jurisdictional Affiliates.

The methods used to inform the NACCHO's IPP review response are provided below:

1. National ACCHO Indigenous Pharmacy Program questionnaire, sent to all NACCHO Member Services
2. Adaption of content from NACCHO's national consultation for the Pharmacy Regulation and Remuneration Review
3. Affiliate Public Health Medical Officer group teleconference
4. ACCHO working group teleconference
5. Teleconferences with individual Member services and Affiliate Representative, in addition to group sessions
6. Structured comprehensive review of relevant peer-reviewed, government and grey literature from 2000-2017
7. Incorporation of ACCHOs' individual responses to the IPP Review
8. Consultation with the joint PSA-NACCHO ACCHO Pharmacist Special Interest Group
9. Discussions with key stakeholders including The Department and The Pharmacy Guild of Australia
10. Discussions with other relevant stakeholders. E.g. Northern Territory Department of Health
11. Structured review of 12 relevant submissions made to the Pharmacy Remuneration and Regulation Review in September 2016
12. NACCHO-facilitated pharmacy policy team workshops
13. Opportunistic Member consultation during the national QUMAX workshop series
14. Review of Aboriginal and Torres Strait Islander health spending, including CTG and s100 costs

Results from NACCHO's consultation overwhelmingly supports findings and recommendations in previous reviews and submissions.

The major outcomes from NACCHO's consultations included:

1) IPPs are highly valued. QUMAX, CTG and the s100 and Support Allowance are attributed to improving quality use of medicines by clients (including medicines access and adherence), particularly for those managing chronic conditions
2) Current funding allocations are not keeping pace with growing community need including increasing prices for goods and services, and increasing numbers of clients requiring QUM services
3) CTG should be available to Aboriginal and Torres Strait Islander people, no matter where they live. This would enable flexibility and contribute to continuity of care for those who need to travel to and from metropolitan areas. Enabling hospital pharmacists and specialists to prescribe CTG scripts was strongly supported.
4) Support to employ a practice pharmacist by ACCHOs would support and provide critical QUM services directly to clients as well as practitioner and CQI-based activities. This model can be adapted to regionally shared or part-time arrangements.
5) The role of Aboriginal Health Workers and Practitioners (AHWs and AHPs) in facilitating and supporting culturally safe QUM work with clients, particularly in the area of Home Medication Reviews (HMRs) was identified as important. The provision of extra resourcing to employ a specific QUM AHW, Aboriginal Health Practitioner, or other Aboriginal health practitioner identified by the ACCHOS, to enable ACCHOs to consider this as an option.
6) The option for ACCHOs to own their own pharmacy was strongly supported.

A summary of consultation outcomes can be found at **Appendix 1**

Section 2 – High value systems changes and innovation

NACCHO Pharmacy Priorities

NACCHO's comprehensive consultation and literature review relating to the Indigenous Pharmacy Programs and medicines policy has been strongly positive to users and effectively met their defined outcomes. NACCHO's consultation has also identified a number of ways that these programs' successes can be built upon. These include minor enhancements of programs and more innovative systems-based solutions that relate to both QUM and medicines access, many of which have been led by the ACCHO sector.

Below are core pharmacy system reforms that stand to deliver great value for all stakeholders. These reforms are designed to improve equity across settings (such as between remote and urban settings) and aim to deliver a seamless client journey. In many cases these changes are not difficult to implement and administer, some are already happening in an ad hoc way and they are already backed by expert informants, organisations and a large evidence base.

Priorities include:

1. Improving integrated pharmacy services in a way that reflects the communities' distinct needs, including:
    a. Support for embedded ACCHO practice pharmacists with a funded and structured program
    b. Further support for regionally shared QUM pharmacists (e.g. QUMPs)
2. Building on community pharmacy capacity to deliver more culturally responsive and value-driven relationships
3. Streamlining or amalgamating current programs to deliver a more seamless journey for all Aboriginal and Torres Strait Islander clients

Other important pharmacy issues:

4. ACCHO pharmacy ownership through legislative amendments and business support
5. A national Aboriginal and Torres Strait Islander medicines group to provide clinical leadership and resources
6. Consideration of PBS reforms suggested by Members

What innovations are currently happening?

While the current pharmacy programs have been exceedingly helpful in supporting services to improve medicines related outcomes, NACCHO has observed a range of ways that Members are using their scarce resources to commission pharmacists and pharmacy services (and goods) beyond and in addition to the traditional GP-retail pharmacy paradigm. NACCHO acknowledges the critical importance of the community pharmacy model in adding clinical value to ACCHO clients' care across Australia. Currently innovations that build on this traditional pharmacy services model observed or suggested by Members and stakeholders include:

1. Pharmacists directly employed by ACCHOs to work as an integrated team member within the organisation
2. Regionally shared independent consultant pharmacists. For example, QUM Pharmacists (QUMPs)
3. Section 90 community pharmacies owned and operated by ACCHOs
4. Independent consultant pharmacists employed casually by ACCHOs to perform clinical and non-clinical duties
5. Community pharmacy commissioned (e.g. through QUMAX) to provide services within the ACCHO, such as education
6. A non-section 90 'private' pharmacy or medicines room embedded within an ACCHO that can provide medicines in a culturally safe and accessible way
7. An externally owned pharmacy embedded within ACCHO premises

Principles of pharmacy services for ACCHOs

While there are advantages to each of the models listed above NACCHO supports three basic principles:

1. **Equity and community control:** Within the validated Aboriginal community-controlled model of care, ACCHOs have equitable access regardless of their location, and maximum control over which of these arrangements and types of pharmacy services they utilise. They are in the best position to appraise which will deliver the best results for their community
2. **Resources:** Necessary support and resources are invested into providing ACCHOs with
    a. information and expertise to assess their pharmacy service needs; and
    b. funds to facilitate procurement of these services.
3. **Seamless care:** All Indigenous Pharmacy Programs should integrate into ACCHO models of care to facilitate a seamless patient journey
4. **Program Governance:** All pharmacy programs delivered to NACCHO Members and clients must commit to a lawful, efficient, prudent and ethical governance that produces effective outcomes. Aboriginal and Torres Strait Islander people and communities must lead the decision making and control of these programs.

Travel and incentives

'Distance and logistics involved in visiting a remote clinic is very costly. Currently we receive a payment for six months of service, with a requirement to visit a clinic once in that period. Clinics often request additional visits which are funded out of our organisations own budget'.

(Respondent NACCHO Members IPP Questionnaire 2017)

During NACCHO's consultation allowances and incentives for pharmacists to travel to remote and regional areas has been consistently criticized as being inadequate. Supporting necessary travel arrangement at realistic rates is a critical equity measure that should be factored into any pharmacy services program. From a general policy perspective, offering incentives for programs, rather than administering rules or legislation may also be preferable. This may improve the flexibility of the program and allow the participating organisations to have more control in how they use a program depending on the needs of their community. RACGP suggested an incentive-based approach within their submission to the Pharmacy Regulation and Remuneration Review. Some incentives that have been suggested that will improve QUM uptake in remote and regional services include: enhanced MBS claiming for pharmacists or Practice Nurse Incentive Payment model expanded to practice pharmacists.

Recommendation:

Adequate funding or incentives, especially for travel, are needed in new and existing programs to ensure uptake and viability, and thus improve equity.

Understanding outcomes of IPPs

Programs currently support strongly evidence-based activities such as improving access to medicines or validated QUM activities such as HMRs and DAAs. There are known limitations to the use of national data to assess effectiveness of programs. For example, s100 PBS data cannot be linked to client records.

Any further quantitative assessment of IPP effectiveness must respect the data ownership, systems and local knowledge that exists. Integration of nKPIs with local and jurisdictional CQI activities could be considered and flexibility to respond to community priorities within outcome evaluation is critical. A community-based participatory research framework could be used to further assess programs' effectiveness and could also be integrated into ACCHOs usual CQI activities. ACCHOs and Affiliates are integrating new technology and information into increasingly advanced CQI strategies to understand intervention and program outcomes on a service and jurisdictional level. For example, CQI could be one component of QUMAX.

Recommendation:

Future assessment of IPP effectiveness must include flexible approaches which respect Aboriginal and Torres Strait Islander communities' data ownership, existing CQI systems and health priorities.

Pharmacy services and ACCHOs

NACCHO has observed many novel pharmacy service solutions evolve to augment the traditional pharmacy environment and programs available to ACCHOs. These local solutions have greatly improved access to QUM and the quality of pharmacy services available to ACCHOs. These arrangements extend beyond or build on the scope of current IPPs, and include:

1. Inter-professional clinical pharmacist consultation within ACCHOs. E.g. a full ACCHO practice pharmacist
2. ACCHO staff medicines education and training by pharmacists
3. Practice-based quality and clinical evaluation activities. E.g. Drug Use Evaluation (DUE), CQI, medicines storage management
4. External stakeholder liaison (e.g. community pharmacy and hospital) and care planning.

Positive health and economic outcomes achieved through supporting pharmacy services have been observed globally and are discussed more extensively in NACCHO's Submission to the Pharmacy Regulation and Remuneration Review. Needs expressed by ACCHOs have been addressed through enhancing support for pharmacy services including:

- Improved health
- Improved health literacy
- Improved adherence to treatment
- Improved medication management and understanding
- Improved care for clients transitioning between care settings (e.g. hospital to home)
- Improved relationships with pharmacies
- Improved clinician medicines knowledge
- Improved medicines utilisation and prescribing

During the Tranche 1 Pharmacy Trial Program period so far NACCHO has spent considerable time consulting with Members and working with the Pharmacy Guild of Australia, stakeholders and academics in developing a Medication Management Review (MMR) service that addresses known issues with current Australian MMRs, including the Home Medicines Review. Because of the Australian Government's public commitment to positive MMR reform for Aboriginal and Torres Strait Islander people, MMRs are not discussed in detail in this submission. NACCHO looks forward to the implementation of this trial. It is critical that knowledge and systems developed during this process are translated into real policy and useful information for ACCHOs across Australia to be implemented as soon possible.

Practice pharmacists in ACCHOs

Currently, inter-professional collaboration regarding medicines is often incomplete or ineffective. Dispensing protocols, the lack of pharmacist interaction and cultural training, and the physical settings of community pharmacies have made it difficult for some Aboriginal and Torres Strait Islander people to have productive relationships with their community pharmacists.[33] ACCHOs play an important role in the primary health care of Aboriginal and Torres Strait Islander people and are generally comfortable, safe environments that provide comprehensive, holistic services in a culturally responsive way. [34]

Currently, pharmacists are providing limited clinical pharmacy services to Aboriginal Australians due to barriers to service provision. [35] These barriers include, but are not limited to, the absence of pharmacist-ACCHO relationships and prohibitive HMR business rules including HMR processes which are not always possible nor culturally acceptable.[36] Having culturally responsive pharmacists integrated into ACCHOs would facilitate building of relationship and trust between pharmacists and patients, ACCHO staff and the community. Such relationships with patients and health professionals will assist delivery of essential medication adherence and medication education services, improve continuity of care and empower Aboriginal and Torres Strait Islander people in their medication choices and management.

'*HMRs have multiple steps and is lengthy and requires numerous appointments that clients do not wish to attend. Clients are not comfortable to have home visits'.*

(Respondent NACCHO Members IPP Questionnaire 2017)

Some ACCHOs have already employed practice pharmacists at regional or individual clinic levels. Despite the compelling evidence supporting practice pharmacists' activities,[37] employment of a pharmacist at an ACCHO may be funded from unreliable income such as MBS surplus, and lacks a formal, nationally recognised framework. Some ACCHOs may also identify the need for a pharmacist but have insufficient resources to employ them. Lack of established funding models limits the uptake and sustainability of such services.

Despite rates of medication misadventure, evaluations of the HMR program indicate that Aboriginal and Torres Strait Islander patients and ACCHOs are underutilising HMRs. [38] [39] Research also shows that the current HMR model is not appropriate to address their needs. [40] Practice pharmacists are in an ideal position to deliver culturally responsive medication management services that require inter-professional collaboration by working with IPPs, community pharmacies and ACCHOs.

Funding and program support for practice pharmacists embedded within ACCHOs is publicly supported by the following organisations or bodies:

8. The Society of Hospital Pharmacists Australia (SHPA)
9. The Pharmaceutical Society of Australia (PSA)
10. The Royal Australian College of General Practitioners (RACGP)
11. The Australian Medical Association (AMA)
12. Aboriginal Medical Services Alliance Northern Territory (AMSANT)
13. Northern Territory Government
14. National Rural Health Alliance
15. NACCHO Board

Recommendation:
A funding mechanism or program to support ACCHOs to utilise a full-time, part-time or regionally shared practice pharmacist if they wish can enhance the capacity of ACCHOs to meet the needs of Aboriginal and Torres Strait Islander patients. NACCHO has recently developed a costed practice pharmacist framework ready to implement.

Funding models for an ACCHO Practice Pharmacist could include:

- Incentives similar to the PNIP scheme
- Fee-for-service billing arrangement such as MBS claiming for medicines management
- A 6CPA funded program, that could be trialled under the Pharmacy Trails Program
- A combination of the above

Some Members have suggested that an incentive payment may better reflect the diversity of pharmacists' roles and minimise administrative requirements. It is also difficult to quantify the diverse activities a pharmacist within an ACCHO can perform.

See **Appendix 2** for further information on practice pharmacists' roles in ACCHOs

Regionally shared pharmacy services

A model for regionally shared pharmacists is well-established. Under the 5CPA, QUMAX (2011-2012) was funded to provide regional QUM support through the ACCHO State and Territory Affiliates and Quality Use of Medicines Pharmacists (QUMPs). The objective was for State and Territory Affiliates and QUMPs to work together to provide regionally specific, culturally appropriate development and implementation of QUMAX work plans.

The role of QUMPs included;

- Providing advice and support to assist and strengthen relationships between ACCHOs and community pharmacies
- Assist in developing QUMAX work plan objectives and Dose Administration Agreements (DAAs) between ACCHOs and community pharmacies
- Provide QUM education and advice to ACCHO staff and their clients
- Work with ACCHOs to develop strategies to maximise QUM such as access to QUM education, Home Medicine Reviews (HMRs), participation in QUM activities such as diabetes and asthma groups and uptake of the Medicare Safety Net by all family members
- Assisting ACCHOs and their clients access other community pharmacy support services

Funding for QUMPs and NACCHO State and Territory Affiliates roles was not provided after 2012. Support for the regional QUMP role is still evident. At the NACCHO and the Guild facilitated QUMAX workshops in November (2016) and March (2017), participants highlighted the significant role of QUMPs in supporting QUMAX and QUM activity at the regional level. This role was highly valued by ACCHOS participating in QUMAX at the time. The vast majority evidence suggests the QUMPs fulfilled their objective and provided much needed capacity for ACCHOs to implement regionally specific and culturally appropriate QUM support to their clients. Given the positive feedback on the QUMP role, the reason for defunding these positions was never fully understood.

QUMPs provide a model for which to build regionally shared pharmacy services. A new model provides an opportunity to consider other pharmacy services within the ACCHO which may align closely with the emerging practice pharmacist model. A regional model for shared pharmacy services would support clients of smaller ACCHOs in States and Territories, with limited resources and access to QUM services and resources.

Recommendation

NACCHO recommends a model for regionally shared pharmacy services is developed and resourced to support clients of smaller ACCHOs access QUM services and resources.

Community Pharmacies

Pharmacy cultural competency and relationships

'*Perhaps a special certification/ qualifications for culturally responsive HMR pharmacists…?*'
(Respondent NACCHO Member Services IPP Questionnaire April 2017)

General feedback from NACCHO consultation has shown that many community pharmacies are delivering effective pharmacy services to ACCHOs in a culturally responsive way. However, there have also been some poor relationships noted within our consultation that are corroborated in previous consultation and in the literature. Poor cultural competence is known to be a significant barrier to Aboriginal and Torres Strait Islander people's access to health services. There are also few practical tools or resources to help build cultural competency and to allow ACCHOs and pharmacies to get the maximum value and effectiveness from these professional relationships.

During recent consultations NACCHO has learnt that there are many proactive dynamic relationships between ACCHOs and community pharmacies across Australia. For example, a tender process for pharmacy goods and services has been used by a number of health services across Australia. Conversely, in other areas ACCHOs may receive inflated prices or poorer service because they do not have the administrative capacity or 'pharmacy literacy' to navigate the pharmacy goods and services market available to them.

Pharmacists and community pharmacies have a growing scope of professional services in addition to the established therapeutic goods provision for which they are well known (for example, dispensing

medicines). A global shift towards integrated, collaborative care means pharmacists now have the potential to have a much greater and more active role in addressing Aboriginal and Torres Strait Islander health priorities. This includes priorities outlined in the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 (NATSIHP) and the Indigenous Primary Health Care National Key Performance Indicators (nKPI).

Using pharmacists' full range of skills and aligning pharmacy services with NATSIHP and National Medicines Policy (NMP) will make an invaluable contribution to improving the health outcomes of Aboriginal and Torres Strait Islander peoples. This will further support ACCHOs and other health services to achieve nKPIs and ultimately assisting to Closing the Gap. As technology develops and the scope of services delivered through community pharmacies grows there is potentially great productivity to be achieved in supporting both parties to build effective, synergistic relationships.

Recommendations

NACCHO recommends the development of a resource package that can be disseminated to all ACCHOs, other Aboriginal and Torres Strait Islander Health Services, and community pharmacies to support the development help both ACCHOs and community pharmacies get the best value from their relationship.

This resource could be led by NACCHO and the Guild and include:

1) Cultural competence framework to help ACCHOs deliver cultural competence training and education to their local pharmacies
2) Templates for ACCHOs to assess their pharmacy needs, including tender/commissioning for pharmacy services
3) Resources explaining current pharmacy services and programs available to ACCHOs
4) Communication resource e.g. explaining how workflow and operations can be improved between organisations, such as use of MHR
5) Other relevant guidelines e.g. The *Guide to providing pharmacy services to Aboriginal and Torres Strait Islander People* PSA 2014

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Streamlining and amalgamating medicines subsidy and QUM programs

The effectiveness of Aboriginal and Torres Strait Islander pharmacy programs in achieving the stated goals and being acceptable to users and clients has been well documented for some time and discussed in detail in Section 1. As too are the ongoing problems associated with how current programs interact, including program fragmentation, poor interoperability and complex rules. A comprehensive systems approach to all IPPs could provide a clear policy platform to move forward with a sustainable plan into the future. Conversely, there is a risk that too many minor incremental adjustments to these programs could make them less navigable and less practical for consumers and health care providers alike.

See *Comparison of Legal Measures to Improve Aboriginal and Torres Strait Islander Peoples Access to Medicines (s100 and CTG)* in **Appendix 3**

Aligning medicines subsidy with a client's individual Medicare number

The value in addressing interoperability

'The ability for a prescriber in an s100 clinic to issue a CTG script to patients would increase access to medicines. When patients are required to travel away from home they experience considerable difficulty obtaining their meds. If they could be provided with a CTG prescription before they leave would make access to medicines easier'

(Respondent NACCHO Member Services IPP Questionnaire April 2017)

Numerous stakeholders and organisations have recommended that CTG annotation and eligibility could be amended and streamlined in several ways. It is likely that these reforms in CTG will improve care for a small proportion of Aboriginal and Torres Strait Islander clients who are travelling, transitioning through care settings or accessing care outside of their usual primary care settings (e.g. an afterhours clinic). However, these clients are often the most unwell, complex and at risk of medicines misadventure.

Feedback from NACCHOs consultations indicated ACCHOs have developed ways to address these issues which have proven burdensome and inefficient, and pose a risk to patient safety. These are sometimes termed "workarounds". For examples clients with a non-CTG script are required to travel back to an ACCHO to have the script rewritten, s100 clients visiting an urban PIP-IHI clinic to get a CTG supply of medicines to tide them over for a few days until they return to their community. Streamlining medicines subsidy schemes across all locations to capture the most vulnerable clients is likely to be a high value option in this instance.

How would it work?

Feedback from NACCHOs consultations strongly supports removing the CTG eligibility and annotation from the Practice Incentives Payment (PIP) and using alternatives to identify eligibility of Aboriginal and Torres Strait Islander people to receive subsidised medicines. Given the current PIP Redesign process, there is an opportunity to change the CTG measure consistent with PIP changes. The very high uptake of Medicare across Australia means linking a client's CTG eligibility with their Medicare number may be the most practical and implementable solution. Use of a single accessible identifier has the potential to greatly streamline the client journey in many settings.

Recommendations:

De-link CTG from Practice Incentives Payment, Indigenous Health Incentive (PIP-IHI)

Link CTG eligibility to the client's Medicare card and removing all geographical constraints of CTG

Features of a Medicare linked CTG scheme could include:

- More easily integrated into a whole of person and coordinated care model such as the ACCHO model of care
    - The scheme could be linked specifically with a DAA subsidy scheme similar to the Veterans' MATES scheme
    - Potential for further integration of pharmacy programs such as linking HMR with DAAs as per the Veterans' MATES model
- The scheme could integrate more seamlessly with other Federal government programs such as My Health Record and Health Care Homes
- Community pharmacies, hospitals and health services have online and live access to Medicare card numbers meaning that clients' eligibility could be automatically and immediately updated as required
- Data could be owned by ACCHOs in collaboration with Affiliates and incorporated into their CQI and assessing programs effectiveness
- Data could be useful for further analysis of medicines subsidy outcomes e.g. linking with clinical nKPIs
- Data could also be used to measure program uptake
- Linking medicines subsidy to the individual client could reduce duplication
- Removing CTG's connection with PIP also addresses several short-term issues identified in Section 3, including
    - Assisting mobile clients and those transitioning through care
    - Addressing pharmacist CTG annotation
    - Addressing hospital and specialist CTG annotation
    - Allowing s100 health service CTG annotation

Limitations and considerations

Any changes to how clients would be identified and eligible for CTG would require a clear implementation and promulgation strategy, especially in remote areas where knowledge of CTG may be understandably low.

The implications of a nation-wide Aboriginal and Torres Strait Islander medicines supply database must also be considered. ACCHO and Affiliate ownership of data will be important to allow these organisations to better understand how the scheme is working for their clients and communities.

If a change in means testing is needed, there are existing models that could be considered at a very general level, such as the Department of Veterans Affairs model. The current connection of CTG to an entitlement card can lead to a frequent need to re-present the card with repeated PBS supplies has been associated to individual experiences of shame and reduced access if subsidy is denied on

these grounds. This represents an opportunity to delink subsidy with Centrelink Entitlement and improve client acceptability.

NACCHO also considers the risk of non-culturally responsive care delivered from non-PIP IHI practices (i.e. because PIP would now not be associated with the subsidy) to be outweighed by the benefits to the vulnerable and high-risk clients who will benefit most from this change. NACCHO also suggests that this change could be accompanied with consideration of barriers to medicines access in remote and non-remote clinics and the s100 RAAHS measure.

A single QUM program that aligns with QUMAX for all geographical locations.

NACCHO's consultation and literature review has highlighted a number of limitations to ways remote Aboriginal and Torres Strait Islander health services receive QUM and pharmacy services. Many stakeholders highlighted the low level of QUM delivery in remote areas generally. NACCHO wishes to highlight some specific challenges noted for the s100 Support Allowance:

1. Two pharmacy visits per year are grossly inadequate for any quality pharmacy service delivery or professional rapport to be developed.
2. Dose Administration Aids (DAAs) are highly valued and commonly used by remote ACCHOs and their communities, but these are not subsidised as they are in non-remote settings (i.e. QUMAX). Subsidising DAAs in s100 services has been recommended by a senate enquiry in 2010. [41]
3. Support Allowance funding is based on the amount of PBS medicines supplied to the clinic. This encourages medicines wastage, which is manifestly a problem according to a small number of stakeholders.
4. Lack of transparency and accountability with the section 100 Support Allowance. [42] ACCHOs are not necessarily privy to funds allocated to their service and may be unable to fully appraise the value of the service provided to them. This lack of transparency has the potentially to influence market conditions and inflate the price of services delivered.
5. Little formal or quantitative appraisal of s100 Support Allowance. NACCHO is also not aware of any support groups or forums for s100 health services to share knowledge. This could improve recipient's consideration of limitations and benefits of s100 and drive better utilisation and value in the program.
6. In some cases, resources are not present to support even basic QUM activities, such as medicines labelling within national guidelines.

During the Pharmacy Regulation and Remuneration Review Submissions in September 2016, many experts and organisations' submissions expressed concerns that QUM arrangements in remote areas were inadequate. This included:

- The Australian Medical Association (AMA)
- Aboriginal Medical Services Alliance Northern Territory (AMSANT)
- Central Australian Aboriginal Congress (CAAC)
- Northern Territory Government
- National Rural Health Alliance (NRHA)

- The Society of Hospital Pharmacists Australia (SHPA)
- Kimberly Aboriginal Medical Service (KAMS)
- The Pharmacy Guild of Australia (PGoA)

The QUMAX program is designed to focus on community control and engagement with pharmacy services. It is based on building relationships between pharmacies and ACCHOs and Members are supported by NACCHO in planning any of a great range of pharmacy services to suit their community's needs. Within QUMAX NACCHO delivers appropriate, tailored program coordination and support that is not attached to any jurisdictional issues – this is not a feature of s100 Support Allowance. ACCHOs are actively engaged in the best way to allocate funds for pharmacy services and this is addressing service gaps well and produces value for the community.

QUMAX data is reported on publicly by NACCHO and the Guild and there is also a greater amount of research supporting QUMAX compared with s100 Support Allowance. While the detailed functions and metrics of s100 Support Allowance and QUMAX are clearly different, NACCHO believes that expanding QUMAX to **all** ACCHOs and retaining some core features of s100 Support Allowance where needed will improve known problems associated with the s100 Support Allowance program including low ACCHO-pharmacy engagement, poor accountability and medicines wastage. This will also allow remote ACCHOs to access DAAs more easily through an existing, well-established process.

ACCHO imprest systems

Many ACCHOs across Australia stock a large number of medicines on site. This is done in remote, regional and in urban settings alike. While ACCHOs cannot own a section 90 pharmacy currently (with the exception of the Northern Territory) many choose to fund large amounts of medicines to be supplied to clients directly from their clinics. This is done out of necessity, to improve client medicines access - ACCHOs are culturally safe, geographically accessible and can provide medicines in a very timely way relative to a client's clinical consultation. In many cases if medicines are not available immediately the clients may not return to the ACCHO and may be even less likely present to a local community pharmacy.

The sequelae of not taking medicines can be disastrous. This method of medicine supply is generally done in two ways: 1) through s100 in eligible remote clinics and 2) the medicines are purchased from a pharmacy and/or wholesaler and provided to clients at a full or partially subsidised rate – often known as an 'imprest' system. Buying and storing medicines in ACCHOs places a financial and resource burden on these services, to both procure the medicines and also manage stock, legal compliance, storage, disposal and administration. Pharmacist are seen to have the most comprehensive training and expertise in managing medicines purchasing, storage and administration and the pharmacist peak body, the Pharmaceutical Society of Australia, have a number of guidelines and standards that relate directly to these activities.

S100 Support Allowance aims to support pharmacists delivering these services to Aboriginal and Torres Strait Islander health organisations, whereas QUMAX has no direct provision for this type of service. Imprest items are supplied through ACCHOs according to jurisdictional laws but a general lack of pharmacist involvement has been noted, including dispensing. This means that comprehensive dispensing and QUM activities usually delivered by pharmacists are sometimes absent when medicines are supplied through imprest arrangements. The clinical value of pharmacist

dispensing and QUM service delivery at the point of medicines supply is foundational to the Australia healthcare system.

Large amounts of medicines currently being supplied through imprest systems across ACCHOs outside of s100 in urban and regional locations. These organisations are observing barriers to their client's access to medicines and proactively addressing these, often through allocation of resources outside of any subsidised program (e.g. Emergency Prescriber Supply). Indeed, one ACCHO employs a full-time pharmacist to dispense medicines privately through the clinic at a direct cost to the ACCHO.

There is debate regarding how non-remote clinics should invest in this activity in comparison to encouraging clients to attend and engage with community pharmacies. It is clear that both approaches are currently required to some degree in virtually all non-remote ACCHOs. This appears to be irrespective of location and is dependent on a number of local factors including pharmacy proximity, pharmacy cultural responsiveness, transport options available, community preference, care model and more. For example, one urban ACCHO that has undertaken extensive geospatial analysis and shown how strongly proximity of services to their clients' residences in metropolitan suburbs affects clients' healthcare uptake significantly.

Recommendations:

All ACCHOs across Australia have access to the core elements of QUMAX, including s100 and remote ACCHOs, and that this is augmented with a provision similar to s100 Support Allowance to assist ACCHOs collaborating with pharmacies in planning relating to imprest and non-QUMAX services.

Any review of s100 service eligibility criteria will require broad consultation with the Aboriginal and Torres Strait Islander communities and organisations. This should occur across all geographical regions of Australia, and that the review should consider how many non-remote, non-s100 eligible ACCHO clients experience significant barriers to medicines access, often necessitating large, expensive imprest systems in ACCHOs to manage this.

In comparison to Figure 1 (in Section 1), below is a graphical illustration how IPPs could work in consideration of NACCHO's recommendations above. This model can improve both equity and efficiency. The client's captured by changes are a minority, but the most vulnerable and high-risk, representing a high value change . Note that the patient journey will be greatly streamlined and current workarounds have been eliminated, which is much more simple for both administrators and clients.

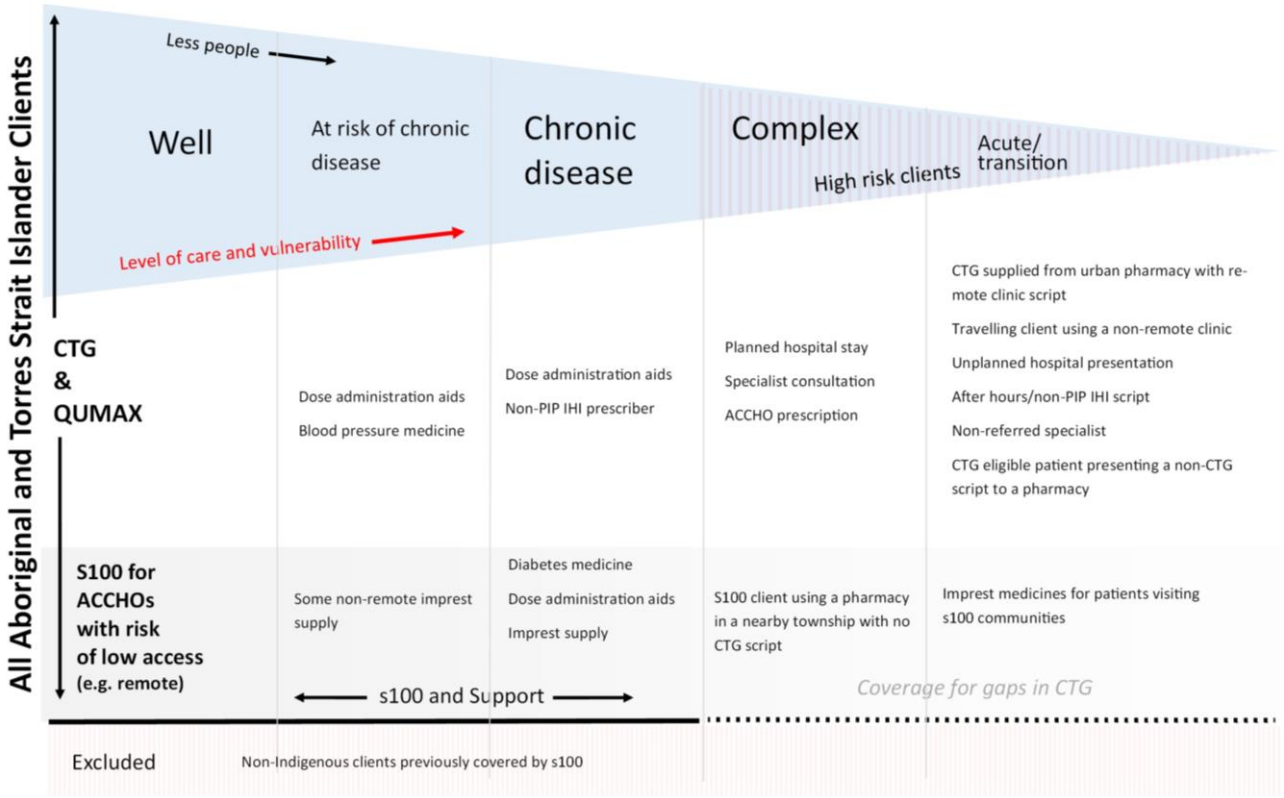

Figure 2 - Proposed simplified medicines program – CTG and QUMAX adapted to remote settings

Any enhancement of current programs that build on ACCHO-community pharmacy engagement stands to improve the uptake of community pharmacy dispensing to ACCHO clients, as opposed to imprest supply. This can improve the system's efficiency, reduce clinic's need to supply imprest at a cost to their organisation and add value to the client's health experience by enhanced uptake of community pharmacy services and goods that are not available through the clinic.

Other systemic recommendations

ACCHO Pharmacy Ownership

NACCHO acknowledges the mutually high-value relationships between ACCHOs and community pharmacies across Australia. NACCHO's consultation supported the need for ongoing relationships with community pharmacies and the effectiveness of IPPs in bringing the two sectors together in many cases. Ongoing engagement with the community pharmacy sector is essential for many ACCHOs to deliver the best results for their communities.

Currently, most pharmacy services for ACCHOs, including dispensing prescription medicines, are provided by external non-ACCHO section 90 pharmacies or hospitals, sometimes at considerable cost to the health service. Research and NACCHO consultation show that ACCHO-pharmacy relationships are quite heterogeneous across Australia. However, recent evidence highlighted how some retail pharmacy services are falling short of the community's needs in a number of ways. [43] [44] [45] Even with subsidised medicines, many clients are not engaging with pharmacy services and occasionally medicines wastage has also been reported.

In addition to enhanced community controlled pharmacy services discussed above, some communities and ACCHOs could also benefit from a culturally responsive pharmacy goods and services model within their organisation that meets the distinct needs of their community. A recent submission to the Pharmacy Regulation and Remuneration Review by the Northern Territory Pharmacy Premises Committee showed their support of an independent review recommending the continuation of ACCHO pharmacy ownership.

Section 90 pharmacy ownership does not mandate large, high-risk retail business model and high costs. Once a pharmacy licence is obtained there is flexibility for an ACCHO's pharmacy business model and capital structure to be low risk. The business model can be tailored depending on the ACCHO's specific needs. For example, the pharmacy could focus on solely providing small amounts of bulk s100 supply to remote clinics.

Pharmacies established, owned and controlled by an ACCHO have the potential to address the majority of medicines needs identified within this submission. This includes, creating a more seamless journey for the client, improving cultural safety of pharmacy services, improving geographical and financial access, medication monitoring and review services and more. Revenue generated through the dispensing of PBS medicines, the provision of pharmacy services and subsidized retail sales could offset federal and state funding.

Key functions could include:

1) High quality, innovative and culturally-appropriate pharmacy services that integrate and complement existing ACCHO range of services;
2) Evidence based strategies that improve medicines access and engagement with pharmacy services;
3) Improved Aboriginal and Torres Strait Islander employment and development;
4) Profits generated are reinvested into programs to improve client and the community health and reduce reliance on government funding sources.

During NACCHO's consultation there was emphatic support for ACCHO-owned pharmacies from a small number of ACCHOs and some stakeholders. Because of the legal barrier for all states and the ACT the concept is not necessarily considered by ACCHOs in these locations. The implementation burden of this change is relatively large but the potential benefits for these ACCHOs and their communities is compelling.

Recommendation:

NACCHO supports ACCHOs in all states and territories having legal capacity to own, operate and control a section 90 pharmacy if that is a need and capability is identified by the community. This would require jurisdictional legislative changes and should be implemented in combination with pharmacy business support and resources.

How it could work:

A coordinated amendment of state and territory legislation to allow ACCHO pharmacy ownership could be implemented with a concurrent business support program to assist ACCHOs in developing effective pharmacy business plans and risk management. The business model itself could be tailored to reduce risk and meet specific community needs. For example, the ACCHO may choose to only focus on distribution of s100 medicines to its remote sites. A large urban ACCHO may choose to capitalise on retail and 6CPA services.

To remove or mitigate barriers to Aboriginal and Torres Strait Islander medicines and pharmacy services access, pharmacies primarily servicing ACCHOs (including those owned by an ACCHO) should be exempt from the Location Rules to facilitate uptake and because the pharmacy would be addressing a distinct community's needs.

A national consultative body to lead Aboriginal and Torres Strait Islander medicines policy

There is currently no national consultative group that provides leadership or current clinical information or guidance for Aboriginal and Torres Strait Islander pharmacy services. Such a body has been recommended in the 2010 senate inquiry into s100 arrangements. The Veterans' Medicines Advice and Therapeutics Education Services (Veterans' MATES) project is a nationwide program that aims to improve the use of medicines and related health services in the veteran community. A team of clinical experts contribute to the writing of this up-to-date health and medicine information which is specifically tailored for veterans and their health professionals. The Senate report *The effectiveness of special arrangements for the supply of Pharmaceutical Benefits Scheme (PBS) medicines to remote area Aboriginal Health Services 2011* recommended**:**

"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."

Medicines use principles in ACCHO settings are sometimes highly specialised and can be complex. For example, there is little research on medicines adherence in ACCHO settings. Currently there is no national organisation or program that specifically addresses medicines-related issues for ACCHOs or

Aboriginal and Torres Strait Islander people. Some stakeholder feedback supports the establishment of this program or group.

Some components of the MATES program which could be transposed to the ACCHO sector include:

1. A coordinated DAA and HMR pathway and cycle of care – where prescribers are prompted to review client's DAA use and consider MMR as part of a structured, ongoing review.
2. The independent group of experts, led by Aboriginal and Torres Strait Islander people, could produce up-to-date medicines information for ACCHO health professionals and clients.
3. The group could facilitate Members and Affiliates to build on their CQI and data capturing strategies to understand pharmacy programs' effectiveness for their communities

The group could involve a consortium or be affiliated with one or more Aboriginal and Torres Strait Islander research institutions. Specific experts could be engaged when required. The group could also provide commentary and clinical leadership on the current IPPs and also PBS medicines listing.

Pharmacy services deficit in remote and regional Australia

A coordinated and sustained approach is also needed to address the ongoing pharmacy services maldistribution across locations. This group would have the capacity to engage all relevant stakeholders and networks, and to appraise the regional and remote pharmacy placement literature, with the aim to provide recommendations on how to address this critical issue. There is a body of evidence for understanding and improving pharmacist workforce in remote and regional Australia and overseas. Validated approaches to address pharmacist shortages include augmenting face-to-face pharmacy service delivery with telepharmacy services; holistic university placement programs that start in the early years of undergraduate degrees, strong and structured organisational support from peak bodies, such as a Guild and PSA mentoring program or support for the Rural Pharmacist Special Interest Group; supporting training and capacity building in medicines skills for ACCHO clinicians, such as AHWs or Remote Area Nurses; and incentivising pharmacy service activities, such as through strengthening fee-for-service pharmacy models or increasing transport allowances. Quality Use of Medicines programs funds should be available directly to ACCHOs for travel and clinical medicines consulting, include funding of both Aboriginal and Torres Strait Islander health professionals (such as an AHP) and pharmacists.

Consideration of PBS

There has been significant Member feedback regarding the current general PBS list and the *Listings on the PBS for Aboriginal and Torres Strait Islander people* within IPP consultation. We feel that some consideration of PBS subsidy relates directly to client access and the National Medicines Policy, and is entirely congruent with the IPP Review's aims. Core PBS themes garnered from literature and NACCHO's IPP Review consultation that could be addressed by this body could include:

- Structured or systematic way of optimising PBS lists and making this process responsive to ACCHOs needs
    - E.g. the need for listing several over the counter items has been raised
- Linking PBS supply information with clinical governance and CQI activities

Recommendation:

NACCHO will explore the establishment of a national consultative body involving all relevant stakeholders. The group will provide guidance and commission some resources with the aim to improve pharmacy services and programs for Aboriginal and Torre Strait Islander people.

Section 3 – Program enhancements to be implemented now

NACCHO has identified some urgent gaps which are currently risking patient safety and causing an unnecessary burden on clients, ACCHOs and the system as a whole. Below are recommended solutions to identified gaps that can very easily implemented outside of any larger health system changes.

Background

Many stakeholders and data shown in Section 1 suggest that programs are working really well, but they are not doing enough due to lack of funds allocated or how they interact. For example, the Australian Medical Association state that subsidy programs "should be strengthened" in their submission to the Pharmacy Regulation and Remuneration Review. Within the 6th Community Pharmacy Agreement Objectives, the following is referenced:

> ***'It is intended that a particular focus of the new, continuing and expanded Community Pharmacy Programmes will be those which benefit Aboriginal and Torres Strait Islander people'***

NACCHO proposes that 'expanding', 'continuing' and developing new and more effective IPPs is incumbent on decision makers within the scope of the 6CPA and the recent Compact between the Guild and The Commonwealth Department of Health.

General enhancements recommended for IPPs

Improving access to pharmacists

Pharmacists workforce

The significant impact of poor supply of pharmacy services and pharmacists to remote and regional areas of Australia is discussed in Section 1. There are currently no incentives or initiatives that have had a significant impact on this problem.

Pharmacists have the capacity to greatly augment primary health service provision across Australia. Pharmacists skills that may be particularly important in these primary health practices and ACCHOs include: medicines management services, stock control and ordering, dispensing, transitional care, medicines skills and capacity building and much more.

A coordinated way of incentivising pharmacists and pharmacies to deliver more services in remote and regional areas is needed beyond what the current 6CPA programs are delivering.

Recommendation:

Provisions for improving pharmacy service access and uptake should be enhanced through current 6CPA QUM programs. For example, this could include grants issued through QUMAX to subsidise pharmacist travel and clinical consultations within regional clinics.

The specialised group referenced in Section 2 could fulfil the role of consultative body to increase pharmacy services access in remote and regional areas.

Aboriginal and Torres Strait Islander clinical staff involvement in QUM programs

'*Recognition of the vital role of AHWs in the HMR process should be expanded. Our service chooses to have an AHW attend each HMR interview with the patient. This helps overcome any cultural or language barriers that may exist. Quite often the pharmacist conducting the HMR is a stranger to the patient. Having an AHW present (most times who is known to the patient), helps to relieve any initial hesitation or uncertainty for the patient and their family about the HMR'*

(Respondent NACCHO Member Services IPP Questionnaire April 2017)

Aboriginal and Torres Strait Islander clinicians including Registered and Enrolled Nurses, Aboriginal Health Workers and Aboriginal and Torres Strait Islander Health Practitioners and others are currently working in ACCHOs across Australia in a number of roles related medicines. These roles are critical to ensuring that the communities and clients care needs are met and that culturally responsive care is delivered. Services are delivered in conjunction with pharmacies' and pharmacists' activities. Perhaps the most common example is accompanying pharmacists to Home Medicines Review visits. Literature and stakeholder feedback has shown that improving the support for Aboriginal and Torres Strait Islander clinicians to augment pharmacy services within IPPs is a highly effective method to improve the quality of care for ACCHO communities.

Recommendation:

Additional resources are made available to enable expansion of QUMAX and s100 to include:

Employment of a QUM Aboriginal and Torres Strait Islander clinician, such as an Aboriginal Health Worker (AHW), within the ACCHO to work closely with patients and their families, local community pharmacists and other health providers

Dose Administration Aids (DAAs)

Dose administration aids are shown to be effective in approving medicines adherence and client health outcomes and cost-effective. DAA use is supported by NACCHO Members across all regions both in their responses to consultation and in their actual usage quantified through QUMAX. Given their effectiveness and acceptability to ACCHOs and clients, subsidy of DAAs must continue to address health disparities between Aboriginal and Torres Strait Islander people and non-Indigenous Australians.

Costs to produce and distribute DAAs to clients and services varies depending on location, technology, the types of DAAs used and other factors. Not all DAAs cost the same amount to produce and quality and acceptability can vary between types and brands of DAAs. NACCHO supports clients have access to the most suitable DAA for their circumstance and preferences. Evidence supports clients choosing the type of DAA that they want to use.[46]

DAAs can be subsidised for clients in a variety of ways in Australia. Within the body of research, there are several factors that have been shown to influence the effectiveness of DAAs. Some

programs in Australia align this evidence with DAA subsidy (e.g. Veteran's MATES). Funding can be stratified into 1) patient-linked or 2) practice-linked DAA subsidy. One example of patient-linked DAA supply is through a PBS prescription for DAA supply. QUMAX offers both a practice-linked and service-linked options. In this case DAA service providers either receive flexible funds based on a patient list provided (patient-linked) or receive a lump sum to provide DAA services to the ACCHO's clients.

Changes to clients' medicines regimens can be onerous and confusing for all parties and administration of DAA services can require significant coordination and communication between organisations.[47] How administration of patient-linked or service-linked DAA subsidy will impact on ACCHOs will vary between sites and depend on different factors. There are some more distinct advantages and disadvantages to models listed below:

Advantages of a service-linked funding

- Encourages practices to negotiate the best value for their clients, therefore potentially reduces to costs of DAAs to the system and improves quality of the service.

Disadvantages of service-linked funding

- Accountability of DAA supply can be low if DAA providers are not acquitted. This could risk wastage.
- If practice cannot negotiate price (e.g. a monopoly) then DAA providers can charge very high prices, creating inequity.
- Bulk DAA subsidy may be more difficult to align with patient-linked programs or services e.g. GP Management Plan or HMR

Recommendation:

All Aboriginal and Torres Strait Islander clients should have access to subsidised DAAs regardless of their geographical location.

Funding models must support ACCHO that are packing DAAs on-site in a way that reflects actual costs in this environment.

Further consultation is needed to determine the best national model to subsidise DAAs for Aboriginal and Torres Strait Islander people. This consultation can consider the advantages and disadvantages listed above.

NACCHO also notes the new s100 dispensing fee increase designed to support DAA provision in remote areas. This is essentially a crude and inefficient way of subsidising DAAs where the cost structure is detached from the actual DAA service cost centres. Also, this arrangement does not support accountability for the quality of DAA services provided.

Close the Gap PBS Co-payment measure

The overtly positive and demonstrable benefits of CTG in addressing medicines access and improving health of Aboriginal and Torres Strait Islander people has been discussed above. The clear consensus from Members and stakeholders is that expanding how CTG can be annotated will improve access to a relatively small cohort of the most vulnerable and high-risk clients. This will:

- streamline the patient journey across care settings and locations
- address the system's inequity
- improve workflow
- minimise the well documented workarounds for services providers and
- will have minimal implementation burden.

This amendment represents policy value – any additional resources related to increased CTG uptake will easily be offset by the improvements. Below are two references that illustrate the issues and summarise how the CTG measure can be amended to achieve these urgently needed improvements.

The NACCHO and the Guild Joint Position Paper '*Closing the Gap Pharmaceutical Benefits Scheme Co-Payment Measure (CTG PBS Co-payment)- Improving Access to Pharmaceutical Benefits Schedule Medicines for Aboriginal and Torres Strait Islander People'* (October 2015) provided a number important recommendations including:

- Linking CTG eligibility to the Medicare card enabling residents in remote area who access S100 to automatically access CTG prescriptions when travelling
- Allowing hospitals to issue patients with discharge CTG PBS prescriptions. This would assist with continuity of care for patients regardless of location or health setting
- Integrating the CTG PBS measure with existing initiatives such as QUMAX
- Grant pharmacist the ability to annotate scripts if patients are already known.

The Society of Hospital Pharmacists of Australia (SHPA) notes their members are concerned with not what CTG Co-payment measure does, but rather the 'gaps it leaves' (Michaels 2017), including:

- Only patients living in regional, rural or urban areas, and who are at risk of chronic disease are eligible
- Excludes medicines listed under the Highly Specialised Drugs Program and other s100 programs
- Hospital pharmacies and hospital medical officers, including specialists, cannot prescribe or dispense CTG prescriptions
- Only GPs have selected to participate in PIP Indigenous Health Incentive can prescribe CTG
- Patients have to prove their CTG eligibility each time, it is not documented officially with Medicare
- The pharmacist cannot amend a prescription (i.e. annotate) if the GP has omitted, it must be returned to the GP[48].

These are barriers to achieving better health outcomes and are contrary to the ethos of the CTG-PBS Co-payment Measure. Hospital Pharmacists recognise that an acute episode of care in a major hospital is an opportunity to implement holistic medicines managements identify problems, improve

adherence and achieve better patient outcomes and treatment goals- opportunities rarely possible under the current model.

Further consultation from NACCHO across the whole of Australia has strengthened the recommendations above. This is in addition to the literature cited in Section 1. These changes to CTG are also a feature of submissions made by both subject matter experts and organisations to the Pharmacy Regulation and Remuneration Review. Organisations publicly supporting CTG annotation changes include:

1. The Pharmaceutical Society of Australia (PSA)
2. The Society of Hospital Pharmacists Australia (SHPA)
3. The Royal Australian College of General Practitioners (RACGP)
4. The Australian Medical Association (AMA)
5. Aboriginal Medical Services Alliance Northern Territory (AMSANT)
6. Northern Territory Government
7. The Pharmacy Guild of Australia

Recommendations:

Link CTG eligibility to the client's Medicare card (discussed in Section 2)

De-link CTG from PIP-IHI (discussed in Section 2)

Allow **all** hospital prescribers to issue patients with CTG prescriptions and allow hospital pharmacies to dispense CTG scripts for all CTG-eligible clients

Allow **all** specialists to issue patients with CTG prescriptions for all CTG-eligible clients

Grant dispensing pharmacists the ability to annotate scripts if patients are known to be enrolled in CTG

Allow all ACCHOs and Aboriginal and Torres Strait Islander Medical Services to be able to write CTG scripts regardless of location (including s100 RAAHS services)

How can it be implemented?

Many of the changes could be implemented immediately simply by amending parts of CTG *Prescriber Eligibility* in the legislation. See **Appendix 4** *CTG Amendment Case Study* for an illustration of the urgency of these changes, the value that changes offer and the simplicity of how amendments could occur.

Currently s100 RAAHS clinics don't necessarily engage with the CTG measure as it only potentially affects a very small number of their clients. Consultation and promotion of how this program could work for these services may be useful to maximise the impact of legislative changes regarding the eligibility to write CTG scripts.

Broader discussions regarding program amalgamation are discussed in Section 2.

QUMAX

Expanding and promoting QUMAX

The QUMAX program supports ACCHOs to commission pharmacy services from community pharmacies that suit their communities' specific needs. This process creates competition and value for ACCHOs, and facilitates both parties to build mutually beneficial, efficient professional relationships. Feedback from Members indicated that support in maximising the relationships and value from pharmacies could be expanded. This is discussed in detail in Section 2.

The Department of Veteran's Affairs DAA programs provides clinical tools to practices maximising the impact of DAAs for clients. The program is also linked with HMRs to add further clinical value. It has been demonstrated to produce beneficial health outcomes in peer-reviewed evaluation.[49] Elements of this program could be transposed into QUMAX to aid ACCHOs to maximise the clinical impact and value of their DAA arrangements.

Home Medicines Reviews (HMRs) are a well-established clinical intervention that have been evaluated generally as efficacious and acceptable to Australian patients. Research shows HMRs are often valued by ACCHOs and their clients but there are several barriers to stop them being utilised on a larger scale.[50] NACCHO's consultation supported this hypothesis. Further support to QUMAX Member Services to build their medication management strategies and capacity could occur through expansion of the QUMAX program. This approach could also be aligned with DAA use, as is adopted by the Veteran's Affairs DAA model of care.

Having QUMAX funding administered by NACCHO means that the actual users' (ACCHOs) interests are represented actively. This creates an accountability and transparency not seen in such programs as s100 Support Allowance.

Opioid replacement therapy (ORT) could be linked to a QUMAX. In a recent Submission to Review of Pharmacy Remuneration and Regulation the Guild strongly supports enhancements to ORT services including '*increasing accessibility to ODT (ORT) services' and 'reducing barriers to access such as, affordability'* and ensuring *'equity of access'.* We also note that the Guild highlight that funding is needed to reduce the cost barrier to access for all Australians (see **Appendix 6**)

As discussed in Section 1, there is clearly insufficient funds and support within QUMAX to deliver all necessary QUM activities that services need to deliver.

Recommendations:
Expand the QUMAX program funding and support, with consideration of:

Building on mutual value through a Quality Use of Medicines resource package developed for all ACCHOs (as referenced in Section 2).

Expansion of DAA component to consider linking with ACCHO care cycles, regular clinical reviews and HMRs

Recommendations: cont.

Annotation relating to ORT within the 'QUM Support' category of QUMAX to allow subsidy or support for a small number of high-risk ORT clients.

Expansion of support for delivering high value medication management services such as HMRs

Expansion of QUMAX to remote and s100 ACCHOs (as discussed in section 2)

Transition of primary control and governance to NACCHO

Integrated Team Care program (ITC)

The aim of the ITC program is to contribute to improved health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through better access to coordinated and multidisciplinary care. ITC can be used to subsidise DAAs and therapeutic devices. Currently ITC guidelines recommend that QUMAX funds must be used preferentially to ITC funds for DAAs and therapeutic devices. *"For eligible patients of ACCHSs, QUMAX must be used to acquire these items rather than making an application to use Supplementary Services* [ITC] *funding."*

Some NACCHO members have expressed their concern that scarce and valuable QUMAX funds are being used due to this ITC program guideline. The ITC budget is about 100 times the size of QUMAX therefore it unreasonable to offset ITC goods or services with QUMAX funds. This reduction in the already very low funds available to ACCHOs for QUM activities is affecting the quality of care that ACCHOs can deliver. This policy is also discordant with the *Primary Health Networks (PHNs) And Aboriginal Community Controlled Health Organisations (ACCHOs) – Guiding Principles*:[51]
*"There **continues to be a need to improve access** to well-run and culturally appropriate health services and programs"*

And it raises questions about the processes listed here:
*"Ensure that the **ACCHO sector is consulted** about all major funding streams (including targeted Aboriginal and Torres Strait Islander funding and mainstream funding)."*
*"With the ACCHO sector convene an **annual stocktake** and forward program workshop on the full range of PHN initiatives affecting Aboriginal and Torres Strait Islander health and wellbeing including: primary health care; aged care; mental health; alcohol and other drug services; and disability services with local ACCHOs (and their Regional organisations, where appropriate)."*

Recommendation:

NACCHO recommends that the wording in the ITC national guidelines is amended to allow the programs to work more synergistically and that ITC does not offset QUMAX funds.

Changing national guidelines would be distanced from local PHN's relationships and thus could take any pressure off affecting functional local relationships.

Section 100 Remote Area Aboriginal Health Service (s100) supply and support arrangements

Stakeholder and Member commentary

Commentary regarding s100 from Members and stakeholders is diverse. Some ACCHOs are happy with the services being delivered within the program's scope, other organisations have publicly called for the entire s100 system to be overhauled or to establish one single medicines subsidy scheme across all locations. Consideration of the patient journey, flexibility for community needs, equitable access to medicines and QUM and the system as a whole is needed if any large-scale changes are to be made to s100. A unified medicines subsidy scheme for all Aboriginal and Torres Strait Islander people offers clear theoretical benefits including:

1. A seamless journey for travelling clients or those transitioning through care
2. Reduced administration burden and costs for all stakeholders
3. Improved equity for those vulnerable clients who currently are being missed by both programs

Risks include:

1. Poor consultation resulting in implementation burden and confusion for health service providers and consumers
2. Loss of program goodwill and undermining of current client and interorganisational relationships
3. Unforeseen incentives or outcomes that produce winners or losers in an inequitable way

Recommendation:

Given the benefits realised by medicines subsidy programs to date ongoing support to improve access to medicines by reducing the cost barrier is critical. If a unified medicines subsidy scheme were to be considered that combines s100 and CTG, NACCHO recommends a round table approach with all relevant stakeholders.

Previous recommendations

In 2012 NACCHO and the Guild authored a Joint Position Paper titled: Improving access to Pharmaceutical Benefits Schedule medicines for Aboriginal and Torres Strait Islander people through the Section 100 Remote Aboriginal Health Services Program.[52] Some of the clear and evidence-based recommendations from this paper have been enacted in the past few years but this has been ad hoc and many programmatic issues remain unaddressed. These issues continue to be supported by stakeholder and Members alike. Below and **Appendix 5** shows selected excerpts from this paper; accompanying new recommendations are referenced after these excerpts below:

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

- NACCHO that the QUMAX model be expanded and adapted to remote ACCHOs as discussed in Section 2
- NACCHO recommends that ACCHO have enhanced access to practice pharmacist through a national program or framework (E.g. through PNIP) as per recommendation in Section 2

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

- NACCHO recommends that CTG prescribing is available for remote ACCHOs and RAAHS as per recommendations above in Section 3.

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

- NACCHO recommends a national consultative body to inform Aboriginal and Torres Strait Islander pharmacy policy, inter-jurisdictional medicines issues, s100 and non-remote ACCHOs as suggested in Section 2.

Dispensing Fee for Remote Aboriginal Health Service enacted January 2017

The new measure to remunerate pharmacists aims to improve equity by enhancing the delivery of the QUM activities (i.e. dispensing) for remote Aboriginal and Torres Strait Islander clients. NACCHO has received some anecdotal feedback that this may be occurring and accepts the rationale for this measure - this is reflected in the recent NACCHO-Guild s100 position paper cited above. NACCHO also acknowledges that funding for this measure is offset from the entire Australia-wide dispensing fee afforded to all pharmacist dispensing activities, and therefore is delivering equity. NACCHO has not been actively consulted regarding implementation or evaluation of this measure so far.

NACCHO strongly supports s100 ACCHOs having direct access to the necessary data to be able to independently determine what their pharmacy business is worth. ACCHOs should be provided an annual report from the Pharmaceutical Benefits Division that documents the number of items dispensed from their service and the total value in dollars of all section 100 prescriptions from their service. The amount paid per item dispensed is known and this allows a calculation of the total income against it. NACCHO has received feedback that the profit margin on the total cost of medicines dispensed in in the order of 10 to 15% conservatively - these data are important in calculating the total value of the business. This approach is critical in ensuring that ACCHOs can negotiate appropriate profit sharing arrangement with any pharmacies who they are working with to supply section 100 medicines from their premises. NACCHO is concerned that without this information there is no transparency and accountability and some pharmacies have not provided sufficient funds back into service delivery from the profits that they have made.

Recommendation:

This measure affects many of NACCHO's Members and thus NACCHO must have the opportunity to provide input and feedback on developments s100 dispensing fee.

s100 ACCHOs must have direct access to their full s100 dispensing data

Currently s100 PBS data is not patient-linked. This is a limitation for health services, researchers and government in being able to measure effectiveness of medicines-related outcomes. Improving individual patient linking for remote medicines supply through this new measure could be addressed.

Section 100 Support Allowance

These QUM services are delivered in accordance with a documented work plan, negotiated and agreed between the participating pharmacy and the ACCHO or AHS. QUM visits should occur regularly and engage patients, as well as providing revision of medicines storage systems and staff training, as funding allows. The s100 Support Allowance has received numerous criticisms as cited in Section 2. Recommendations are provided in Section 2.

Appendices

Appendix 1: Key findings from the 'Combined Review of Fifth Community Pharmacy Agreement Medication Management Programmes: Final Report' (January 2015)

- 5CPA programmes and services were perceived by stakeholders and health practitioners to add value as part of an overall prevention strategy for consumers. Stakeholders and health practitioners also perceived that programmes and services were well aligned with overall policy intent to increase the role of pharmacists working with consumers to improve their confidence and medicines management and contribute to better health outcomes.
- Consumers indicated a level of satisfaction with Medication Management programs and services delivered by their pharmacists.
- 5CPA programs were delivered as standalone programs
- Individual 5CPA programs and services were seen fulfilling a specific purpose, with little integration and interaction between programs and services. Also, noting the linkages or pathways are unclear between programs
- Minimal areas of overlap or duplication between programs exist, however a majority of practitioners reported there were ongoing gaps in existing services, resulting in unmet needs of the consumer
- Stakeholders and practitioners indicated the 5CPA programs were difficult to access for consumers due to low consumer awareness, information on programs not readily available, low GP engagement and awareness to refer consumers to the relevant program, particularly Aboriginal and Torres Strait Islander peoples.

Appendix 2: ACCHO Practice Pharmacists role explained

Pharmacists are now playing an important role in primary health care reform with an expanding set of roles of responsibilities that need to be supported in a model within Aboriginal health settings. A framework needs to guide the development of these expanded roles to optimise health outcomes for Aboriginal peoples in ACCHOs and other primary care settings.

ACCHOs should be supported to employ full-time, part-time or regionally-shared pharmacists (operating from a central 'hub' providing visiting services to 'spoke' ACCHOs). These pharmacists could be defined as 'Practice Pharmacists' providing direct patient care and follow-up, documenting encounters in health records, working with Aboriginal and Torres Strait Islander Health Practitioners, Aboriginal Health workers, doctors and nurses, and providing other services in accordance with defined roles and competencies.

Roles will vary depending on the geographic setting and priorities of the ACCHO, patient profiles and health needs. However, there are four broad roles for a practice pharmacist within an ACCHO are Patient focussed, Practitioner focussed, Practice focussed and Liaison role. Strong links with community pharmacy are a feature of practice pharmacist roles.

The benefit to health and economic outcomes of embedded Practice Pharmacists have been widely researched and supported across many settings and economic analysis of general practice-based pharmacists demonstrated substantial cost savings through reductions in overprescribing, reductions in adverse events, and reductions in PPH. Funding comprehensive primary health care to a level that delivers a critical mass of workforce and service capacity is an equity-producing strategy that can help offset the impact of social inequality on the health of Aboriginal peoples and Torres Strait Islanders.[1]

Appendix 3: Comparison of Legal Measures to Improve Aboriginal and Torres Strait Islander Peoples Access to Medicines (s100 and CTG)

Measure feature	s100	CTG	Suggested ACCHO preference
Primary medication supply or dispense site	Health Service	Pharmacy	S100 and CTG, depending on ACCHO preference
Dispensing service supported/subsidised	Yes*	Yes	CTG
QUM support scheme	S100 Support Allowance	QUMAX	QUMAX
QUM/support features	Based on PBS supply volume Not commensurate with remote needs	Based on ACCHO client numbers Broader scope, with DAAs included	QUMAX
Cost	$0	$0 or Concession rate	S100
S8, DVA and extemporaneous	No	Yes	CTG
Patient linked data	No*	Yes	Requires further consultation
Pharmacy contract required	Yes	No	CTG
Patient criteria	Attend approved remote practice	Attend PIP practice Chronic disease or risk Would 'experience setbacks' without CTG	All Aboriginal and Torres Strait Islander clients eligible as per further consultation
Practice Incentive Payment linked	No	Yes	S100
Highly specialized drugs	No	Yes	CTG
Annotation required by prescriber	No	Yes	S100
Concession and Medicare card linked	No	Yes	Requires further consultation

Measure feature	s100	CTG	Suggested ACCHO preference
Hospital prescribing	No	No (except specialist – see below)	Any hospital in Australia
Specialist prescribing	When providing services at a remote Indigenous Health Service	When 'Providing services at a non-remote Indigenous Health Service; or Treating an eligible patient that has been referred by a GP from a Indigenous PIP or participating Indigenous Health Service'	All specialist without criteria
Health service/ practice eligibility	Must be remote and 'primarily Aboriginal and Torres Strait Islander patients' Safe, adequate and secure storage facilities	Any non-remote practice can sign up to Indigenous PIP if an 'open practice' and accredited	Any practice in Australia
Interoperability	Only remote patients are eligible for s100	NO geographical restrictions^ s100 clients can receive CTG	CTG
Key factors/limitations identified	Extent dispensing fee improves QUM is unknown QUM support program is limited Clients cannot receive s100 when travelling (though some sites have arrangements with community pharmacies)	Dispensing not necessarily culturally safe and off ACCHO site Linked to practice AND Concession cards Hospital prescribing excluded Annotation required	Only Medicare linked (no PIP) Culturally responsive and optimal QUM and dispensing Enhance QUMAX DAA funding as per DVA

* Some pharmacies are dispensing s100 medications beyond the current wholesale supply funding. This is subsidized by DoH as of 1/1/2017.

^ "a prescriber who ordinarily uses the S100 RAAHS PBS arrangement **is also** allowed to write CTG PBS scripts for their patients as long as all of the following apply:

1. the prescriber has a PBS prescriber number
2. the practice is registered for the PIP Indigenous Health Incentive
3. the patient is registered for the PBS CTG co-payment measure.

Appendix 4: CTG Amendment Case Study

Serious limitations to CTG prescription annotation - causing major risks to vulnerable patients and unnecessary costs to the health system (Credit: Aboriginal Health Council of Western Australia)

The aim of the CTG PBS Co-payment measure is to improve access to essential medications for Aboriginal people "*who present with an existing chronic disease or are at risk of a chronic disease and, in the opinion of the prescriber would experience setbacks in the prevention or ongoing management of chronic disease if they did not take the prescribed medication and are unlikely to adhere to their medications regime without assistance through the measure*"[53].

The measure has been enormously positive in the primary care setting but unfortunately often fails to meet the needs of arguably the sickest and most vulnerable Aboriginal patients – those being discharged from hospital.

Currently, this omission has its most profound impact on rural and remote patients with complex chronic disease(s) who (for safety reasons) require their medications packed in "blister packs". This is particularly the case where travel home can take several days or where the patient is required to spend time in Perth for out-patient follow-up or airline clearance.

Although, at this point in time[54], most Perth hospitals directly provide discharge medications free of charge, they can only provide "loose" packets and bottles as they have no facilities to make blister packs. A plastic bag of multiple medications is clearly dangerous for patients with limited vision, limited literacy or limited understanding of complex dosage regimes and no carer support.

This problem could be fairly simply solved if hospital doctors were able to annotate PBS prescriptions and have blister packs made up, on discharge, by a nearby community pharmacy.

The current prescriber restrictions for CTG annotation make this impossible. Although the rules state that a specialist can annotate the prescriptions, in reality prescriptions are almost always written by junior hospital staff. Moreover the rules also state that the patient must have been referred to the specialist by a GP participating in the PIP IHI measure. Again, in reality, many patients are not referred in the conventional way but flown down to Perth by RFDS or transferred from a regional hospital.

Complex workarounds have evolved over the years to try to improve the safety of discharge medications for this vulnerable group. These systems, however, are complicated, time-consuming and very costly. They are also very patchy and usually only available during week day office hours. [55]

This problem of safe hospital discharge medications would be largely resolved by allowing all hospital doctors to annotate discharge prescriptions with CTG. Prescriptions could then be sent directly to a near-by community pharmacist and blister packs made up in a timely and efficient manner – at the point of discharge. Moreover, the system would work for patients beginning their homeward journey immediately post discharge and for those discharged in the early evening or at the weekend.

A "proof of concept" trial, using special funding, has been conducted for cardiology patients attending Royal Perth Hospital with great success. Patients have been able to leave the hospital with safely packed medications with minimal delay. The cost of the co-payment (covered by the trial funding) was calculated to be similar to the cost of the "one off" MBS GP consultation required to obtain CTG annotated scripts outside the hospital. (The cost of transport to the "one off GP" was not specifically calculated but clearly adds very significantly to this MBS cost.)

We believe that relatively minor changes (in red below) to the wording of the current prescriber eligibility criteria would have an enormous impact on patient safety at minimal cost to the Commonwealth and a reduction in overall cost to the health sector[56].

Prescriber eligibility

The following prescribers are eligible to provide their patients with a Closing the Gap annotated script (the bold red is suggested additions and the strikethrough where there is a suggested deletion):

- *any medical practitioner working in a practice that is participating in the Indigenous Health Incentive under the Practice Incentives Program*
- *any medical practitioner working in an Indigenous Health Service in rural or urban settings*
- *any medical specialist* ***or their junior medical staff member*** *in any practice location, provided the patient is eligible under the Closing the Gap - PBS Co-payment Measure,* and ***is a regular patient*** ~~***has been referred by a medical practitioner working in***~~ ***of*** *a practice that is participating in the Indigenous Health Incentive PBS Co-payment Measure under the Practice Incentives Program*

Appendix 5: NACCHO and the Guild authored a 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 - Excepts

The joint position paper Improving access to PBS Medicines for Aboriginal and Torres Strait Islander peoples through Section 100 RAAHS Program submitted to the Senate Community Affairs Reference Committee, noting "in summary, the committee has formed the view that the program has been successful in increasing access to PBS medicines through participating AHSs"

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

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:

- *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*
- *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 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 s100 Support Allowance 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 Support Allowance and its quality assurance to RAAHSs.*

NACCHO that the QUMAX model be expanded and adapted to remote ACCHOs as discussed in Section 2

NACCHO recommends that ACCHO have enhanced access to practice pharmacist through a national program or framework (for example through PNIP) as per recommendation in Section 2

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." 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.

NACCHO recommends that CTG prescribing is available for remote ACCHOs and RAAHS as per recommendation above in Section 3.

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.

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.

NACCHO recommends a national group to inform Aboriginal and Torres Strait Islander pharmacy policy, inter-jurisdictional medicines issues, s100 and non-remote ACCHOs as suggested in Section 2.

Appendix 6: Opioid replacement therapy (ORT) and QUMAX

The effectiveness ORT in improving clinical and non-clinical outcomes is very well established and methadone is currently listed in WHO's List of Essential Medicines. A body of research has shown that those with opioid-use disorders using ORT have significant reduction in mortality, decrease hepatitis, crime and illicit-substance use and improve social functioning.[57] ORT is also shown to be a cost-effective intervention. [58]

ORT services are more than simply issuing or administering a prescribed opioid dose. The service involves a pharmacy fostering a rapport with a patient and providing a holistic service that relates to the patient's health needs in the context of their opioid use and aligns with other primary care professionals involved in their care (such as their Aboriginal Community Controlled Health Organisation). During daily consultation in community pharmacies ORT clients can experience consultations that involve a number of key QUM service components listed in the National Medicines Policy including, managing co-existing medical conditions and therapies; monitoring outcomes; minimising misuse, over-use and under-use; and improving people's ability to solve problems related to medication.

In a recent Submission to Review of Pharmacy Remuneration and Regulation the Guild strongly supports enhancements to ORT services including '*increasing accessibility to ODT (ORT) services' and 'reducing barriers to access such as, affordability'* and ensuring *'equity of access'.* NACCHO also notes that the Guild highlight funding is needed to reduce the cost barrier to access for all Australians. Currently many community pharmacies must charge dispensing fees for Opioid Replacement Therapy (ORT) to offset the costs of providing this service to the community. Research has shown that cost is an ongoing barrier to both ORT treatment entry and retention across Australia. [59] Indigenous Australians are known to be sensitive to affordability of healthcare and this has been demonstrated specifically for ORT. [60]

In some jurisdictions dispensing is free of charge when provided by the public hospital system. Once stability have been achieved, the cost disincentive of moving to a private prescriber and dispensing pharmacy means that the individual remains under the care of the hospital provided and is thus disadvantaged by the fragmentation of their care. Returning to care in an ACCHO setting would ensure that other areas of their health such as preventative health are addressed. In the ACCHO setting it would also mean that the health needs of their family, particularly children, could be better met by the extended team. Anecdotal evidence from clients also suggests that contact with other clients at the hospital pharmacy can also be detrimental and may be the cause of relapse. Clearly moving Aboriginal clients away from the Public Hospital system would also lead to a reduction in waiting time for therapy for other clients.

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[54] It is possible that, in future, PBS prescriptions will be given to all patients on discharge rather than medications themselves
[55] *As an example of a "workaround", Royal Perth Hospital uses Aboriginal Liaison Officers from an outside agency to collect rural or remote patients from the hospital at discharge and transport them to a PIP IHI registered GP practice in the Perth suburbs. Patients then wait for a consultation with a GP who reviews their discharge letter and rewrites the hospital discharge prescriptions – annotating them with CTG. Medicare is billed for a consultation and the GTG prescriptions are taken to a local pharmacy where a DAA is made. Once the DAA is available the patient is transported to the medical hostel. Not surprisingly, the process takes several hours and can be an enormous strain on patients who have just been discharged from hospital.*

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