The Pharmacy Guild of Australia

Ref: 269937

4 October 2012

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Sir/Madam

Submission to Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health report "Closing the gap within a generation"

Thank you for the opportunity to provide a submission to Australia's domestic response to the WHO Commission on Social Determinants of Health report "*Closing the gap within a generation.*"

The Pharmacy Guild of Australia wishes to highlight to the Committee some of the key policies and programs that have been implemented to close the gap in relation to access to medicines and health services through community pharmacy and recommendations to improve the scope and the impacts of the Government's policies and programs.

The Guild is guided by the principle that all Australians have a right to equity and access to community pharmacy services. This is because timely and reliable access to subsidised medicines and Quality Use of Medicines (QUM) services are an essential component to the improvement of health within a community and to achieving health equity.

It is paramount that community pharmacy and the many services provided through this community-based network of health professionals are considered in any Government's response to the WHO report in relation to the WHO Commission's overarching recommendations and principles of action, namely: improving the daily living conditions, tackling inequities in the distribution of resources and developing the workforce that is trained in the social determinants of health.

Infrastructure of community pharmacy

- As primary health care providers, community pharmacists are often being the first point of contact between the public and the health care system, with more than 400,000 people visiting Australia's 5200 community pharmacies each day[1]. Individuals who are healthy and unwell visit community pharmacies, providing an opportunity to engage people along the health spectrum and hard-to-reach populations who do not utilise other health services. Community pharmacy is the only health professional service to have expanded its rural services over the last decade.

[1] Guild Digest 2011

National Secretariat
Level 2, 15 National Circuit, Barton, ACT 2600 Australia
PO Box 7036, Canberra Business Centre, ACT 2610 Australia
Telephone: + 61 2 6270 1888 · Facsimile: + 61 2 6270 1800
Email: guild.nat@guild.org.au · Internet: www.guild.org.au

The Guild estimates that over 1,000 (20%) of the total 5,200 community pharmacies across Australia are located within Categories 2-6 of the Pharmacy Access/Remoteness Index of Australia (PhARIA)[2].

Pharmacy Workforce

- Rural programs and services provided as part of the Community Pharmacy Agreements aim to maintain and improve access to quality community pharmacy services for rural and remote Australia. They also seek to increase the proportion of the total pharmacy workforce starting practice in rural and remote Australia and to retain the pharmacy workforce already there. These programs ensure that Australians pay the same prices for their Pharmaceutical Benefits Scheme (PBS) medicines no matter where they live and that rural and remote community pharmacies can remain viable.

The s100 Remote Aboriginal Health Services Program (s100 RAHSP)

- The s100 Remote Aboriginal Health Services Program (s100 RAHSP) has greatly improved access to medicines listed on the PBS for Indigenous Australians in remote Australia.[3] This program addresses a number of the social determinants of health; for example, it utilises the existing infrastructure provided at the remote area Aboriginal Health Services (RAAHS's), it does not require the patient to travel long distances to the community pharmacy, and it allows the patient to access medicines in a culturally appropriate setting. The Guild hopes that the Government's response to the 2011 Inquiry by the Senate Community Affairs References Committee will provide the opportunity to review the scheme in light not only of the Senate report, but also of the numerous reviews and evaluations which have preceded it.

Closing the Gap – PBS Co-payment Measure

- From a social determinants perspective, there are a number of limitations to the Commonwealth funded Closing the Gap)CTG) – PBS Co-payment Measure[4] that need to be addressed to improve access to medicines for Aboriginal people and Torres Strait Islanders. These include increasing access by eligible people to the measure regardless of 'where they see the doctor' or 'who the doctor is'; for example, attendance at non-accredited medical practices, public hospitals as an outpatient or upon discharge. Further, recognition of registration of an eligible patient should extend to all PBS prescriptions rather than having a reliance on prescription annotation by the medical professional. The Guild believes that for patients who are known to be registered (for example, by pharmacy dispensing software profiles), community pharmacists should be able to make a professional judgement for scripts not annotated with CTG; without having to contact prescribers or send the patient back to the medical practice.

[2] http://www.adelaide.edu.au/apmrc/research/projects/pharia/

[3] Under the s100 RAHSP clients of RAAHS's are able to receive PBS medicines from AHS staff at no cost and without a PBS prescription at the time of consultation. Medicines are ordered by the AHS through a local community pharmacy and then supplied in bulk to the AHS, with no co-payment charged to AHS clients. Pharmacists receive a fee which is less than the normal payment for carrying out this service.

[4] http://www.medicareaustralia.gov.au/provider/pbs/prescriber/closing-the-gap.jsp

Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islanders (QUMAX) Program

- The health of Australia's Indigenous peoples is also a concern for urban areas, which is assisted from a medicines perspective through the Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islanders (QUMAX) Program[5]. Since the introduction of the QUMAX Program in 2006 there has been increased access to the PBS for clients of ACCHSs, increased patients understanding and self-management of their own conditions and a subsequent improvement in health outcomes.

Pharmacy workforce schemes for Aboriginal and Torres Strait Islander people

- There is a need to develop strategies to encourage more Aboriginal and Torres Strait Islander people to enter the workforce, particularly as health professionals, who can then assist in developing social capital and health service provision within their own communities. The Guild is helping to facilitate this through the Aboriginal and Torres Strait Islander Pharmacy Scholarship Scheme (ATSIPSS) and the Aboriginal and Torres Strait Islander Pharmacy Assistant Traineeship Scheme (ATSIPATS) but more needs to be done.

Inter-professional education and training focus

- It is essential that the issues of collaboration and teamwork between health professionals are addressed, and this needs to begin at the undergraduate level. This would support the move to introduce new models of care with an inter-professional focus and teamwork for an effective health care workforce, particularly in rural and remote communities. It is thus essential for Universities to be capable of developing their courses according to developments within the profession so that graduates are fully prepared to provide progressive services within the new health care landscape.

Legislative variation across jurisdictions

- One of the most significant barriers to achieving change is the variation in legislation between the jurisdictions. From the pharmacy perspective, all jurisdictions have legislation controlling the storage and supply of medicines and poisons. The development of national legislative instruments have facilitated greater standardisation, but there are still minor variations between jurisdictions which can be problematic, particular for prescribers, pharmacists or consumers that move across jurisdictions. This is a particular issue for people receiving palliative care, who often require large quantities of opioids for effective pain control, sometimes over lengthy periods of time. Regulatory discrepancies between jurisdictions can inhibit access to these essential medicines, particularly for communities on state or territory borders where patients may travel across jurisdictions. The ideal would be to have greater national legislation and/or legislative instruments which are recognised by the jurisdictions so that health practitioners deal with a consistent set of legislative requirements irrespective of where they practise.

[5] The primary aim of the QUMAX Program, a joint initiative of the Guild and the National Aboriginal Community Controlled Health Organisation (NACCHO), is to improve the health outcomes of Aboriginal and Torres Strait Islander peoples attending Aboriginal Community Controlled Health Services (ACCHSs) in urban and rural areas.

Health Literacy

- The health literacy of the Australian population needs to be addressed, particularly Aboriginal people, Torres Strait Islanders and those from non-English speaking backgrounds. From a QUM perspective, this includes culturally appropriate resources for discussing the safety and administration of medicines, for example, pictorial rather than text based. Consumer Medicines Information (CMI) resources are available through community pharmacy in large print, braille and audio.

Harm minimisation programs

- Investment needs to be made in harm minimisation activities. Issues such as access, affordability and flexibility for opioid-dependent people as well as training for the community pharmacy workforce currently limit the reach of Opioid Dependence Treatment (ODT) in Australia and subsequently the number of persons participating in such programs. Evidence has demonstrated that treatment is effective in reducing the health, social, crime and economic burden of opiate misuse[6]. There is currently little uniformity in the way ODT programs are implemented between States and Territories in Australia, and no uniformity in the cost of dispensing fees to consumers, which can also differ between pharmacies in the same State or Territory. Community pharmacy makes-up 86% of ODT dosing points in Australia[7]. In addition, 72% of Needle and Syringe Programs (NSPs) available in Australia are through community pharmacy, where NSPs averted an estimated 96,667 new HCV and 32,050 new HIV infections in Australia between 2000-2009[8].

Telehealth

- Utilising the existing pharmacy infrastructure would be the most logical and cost-effective means to conduct telehealth services. Pharmacy should be viewed as an 'other health care facility' in which a patient can access telehealth and video conference to a specialist at another location. In the instance where the GP is removed geographically from both specialist and patient, the patient's GP would ideally have the opportunity to participate in a three-way consultation that includes the patient and medical specialist. This would be comparable to the exemption provided under the telehealth initiative to residential aged care services, Aboriginal Medical Service (AMS) and Aboriginal Community Controlled Health Service (ACCHS), which are able to provide telehealth consultations without a Medicare provider number.

[6] 'Methadone Maintenance Treatment and other Opioid Maintenance Therapies' (1998) Ward, J., Mattick, R.P., & Hall, W. (eds). Amsterdam, Harwood Academic Publishers.
[7] Australian Institute of Health and Welfare (2011) 'National Opioid Pharmacotherapy Statistics Annual Data Collection: 2010 report'. Cat. no. HSE 109. Canberra, AIHW.
[8] National Centre in HIV Epidemiology and Clinical Research (2009) 'Return on investment 2: Evaluating the cost-effectiveness of needle and syringe programs in Australia'

In conclusion, community pharmacy will continue to redefine itself given the significant changes occurring to the Australian health landscape. This represents an opportunity for an expanded role, incorporating both consolidation of current services and the development of new professional services with greater focus on the social determinants of health.

We trust that the Committee will commend the policies and programs outlined in this submission to the Australian Government so that these can be provided to the World Health Organisation as Australia's evidence on what can be done to promote health equity as part of the global movement in closing the health gap in a generation.

Yours sincerely

Wendy Phillips
Executive Director