SHPA submission to Review of the National Agreement on Closing the Gap – Draft Report, October 2023

Introduction

The Society of Hospital Pharmacists of Australia (SHPA) is the national, professional organisation for the 6,100+ Hospital Pharmacists, and their Hospital Pharmacist Intern and Hospital Pharmacy Technician colleagues working across Australia's health system, advocating for their pivotal role improving the safety and quality of medicines use. Embedded in multidisciplinary medical teams and equipped with exceptional medicines management expertise, SHPA members are progressive advocates for clinical excellence, committed to evidence-based practice and passionate about patient care.

SHPA has been a longstanding advocate for the Closing the Gap priority reforms and supports initiatives and innovations of hospital pharmacists to improve health outcomes for Aboriginal and Torres Strait Islander communities. SHPA convenes an Aboriginal and Torres Strait Islander Health Specialty Practice Group with over 220 members.

In the past decade, SHPA has made various submissions to government regarding Closing the Gap and First Nations health, particularly around access to medicines given the existing inequities in current policy design. These recommendations remain relevant to health portfolio matters raised in the National Agreement on Closing the Gap – Draft Report.

SHPA recommendations:

- Public hospital pharmacists should be able to register eligible Aboriginal and Torres Strait Islander people for the Closing the Gap (CTG) Pharmaceutical Benefits Scheme (PBS) Co-payment Program on Services Australia's Health Professional Online Services (HPOS).
- Public hospital pharmacies should be able to supply PBS medicines to Aboriginal and Torres Strait Islander people under the CTG PBS Co-payment Program
- The CTG PBS Co-payment Program should be expanded to include all medicines listed under Section 100 programs.
- Section 100 Remote Area Aboriginal Health Service (RAAHS) program rules should be amended to enable a RAAHS approved pharmacist or hospital authority to supply Dose Administration Aids (DAA) and provide relevant counselling directly if patients they are travelling outside of their remote locations and require access to their DAAs from the RAAHS's packing and supplying pharmacy.
- Enable Section 94 public and private hospital pharmacies to be Approved Service Providers and participate in the IDAA Program

If you have any queries or would like to discuss our submission further, please do not hesitate to contact Jerry Yik, Head of Policy and Advocacy

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Summary of SHPA's submission

SHPA endorses the National Agreement on Closing the Gap's collaborative effort between the Australian government and Indigenous leaders and communities to address the profound disparities and inequities experienced by Aboriginal and Torres Strait Islander people across all socio-economic determinants including health, to achieve life outcomes equal to all Australians.

SHPA welcomes the opportunity to provide feedback on the Draft Report and will be addressing Draft Recommendation 2 and Key Information Requests 2 and 11. While the agreement itself does not specifically address public hospitals, the health component of the agreement has important implications for healthcare delivery, including in the context of public hospitals.

A summary of our views relevant to the Draft Report are:

- SHPA supports the development of diverse health leadership teams to promote jurisdiction wide change to achieve Closing the Gap priority reforms.
- Collaboration should be facilitated across all levels of government and the Coalition of Peaks in the implementation of Closing the Gap priority reforms.
    - Expansion and standardisation of the role of Aboriginal Community Controlled Health Organisations (ACCHOs) in transitions of care and medications management to deliver safe and timely wrap-around care to the Indigenous communities.
    - ACCHOs should have the ability to obtain PBS approval numbers allowing them to act as a pharmacy eligible to dispense PBS medicines for their community and provide pharmacy services for Aboriginal and Torres Strait Islander people, improving medication access and adherence by Indigenous patients in a culturally safe manner.
    - Consideration of creating roles such as a National Indigenous Health Commissioner and Chief Pharmacist at the Commonwealth level to be used as health sector-specific accountability mechanisms.

Draft Recommendation 2 - Designating a senior leader or leadership group to drive jurisdiction-wide changes.

SHPA is broadly supportive of this recommendation noting that there is a need for a health sector specific leadership group to drive jurisdiction-wide changes relating to health for Indigenous people. These leadership groups should involve diverse groups of people with multidisciplinary health backgrounds to enhance culturally appropriate healthcare delivery. For many years, Indigenous Australians have experienced significantly poorer outcomes in areas of health compared to other Australians. The burden of disease for Aboriginal and Torres Strait Islander peoples is currently 2.3 times that of other Australians.[1] This disparity has persisted despite various policy efforts aimed at addressing them.

Pharmacists are integral to health leadership groups to drive relevant jurisdiction-wide changes, and should be involved in the design, implementation and evaluation of policies and programs that support access to medicines and pharmacy services. Gaps in existing programs such as the exclusion of public hospital pharmacies from participating in the CTG PBS Co-payment Program, and limitations of the Section 100 RAAHS Program rules creating barriers for Indigenous people accessing their Dose Administration Aids (DAAs), arise from inadequate consultation with health leaders across the acute care setting.

Example 1: CTG PBS Co-payment Program

The CTG PBS Co-payment Program currently excludes public hospital pharmacies from participating in this program. Where Indigenous patients would be able to access reduced co-payments in community pharmacies and private hospitals, some patients are charged their regular applicable co-payment when receiving medicines from public hospitals after discharge from hospital or after an outpatient appointment.

Where public hospital pharmacists have made attempts to facilitate supply of medicines for the patient from a community pharmacy, they are further hindered by not being able to register eligible Aboriginal and Torres Strait Islander people for the CTG PBS Co-payment Program via HPOS. Public hospital pharmacists do not have a commercial incentive and should be able to register eligible patients to facilitate continuity of care and vital medicines access.

Additionally, the CTG PBS Co-payment Program currently only enables reduced co-payments for Section 85 General Schedule PBS medicines, and not medicines listed under Section 100 programs such as the Highly Specialised Drugs Program, Efficient Funding of Chemotherapy, and Opiate Dependence Treatment Program.

These issues have resulted in ongoing inequity in the provision of medicines to Indigenous people in public hospitals, reducing their medication adherence and impacting their ability to meet treatment goals and improve their overall health. In many instances the current policy design does not place Indigenous patients at the centre of its care, often impacting their access to medicines.

Research shows that Indigenous people have lower medication adherence compared to other population groups[2], and that over a quarter of patients fail to make it to a local pharmacy until days later to have their discharge prescription dispensed.[3] Poor access to medications can potentially compromise a patient's health and cause preventable hospital readmissions. This also prevents the provision of expert advice related to the new medication regimen by the pharmacist who has counselled them during their inpatient stay. Hospitals also have better access to Aboriginal Health Workers who can support the medication counselling process at discharge providing culturally appropriate and safe care.

Some states and territories are using their hospital budget to absorb the co-payment costs to attempt to correct the inequity caused by the Federal Government's exclusion of public hospital pharmacies from participating in the CTG PBS Co-payment Program. Hospital pharmacists are involved in various workarounds across Australian healthcare settings to facilitate access to the CTG PBS Co-payment Program, often leading to high variability and inconsistency in the quality of care being provided, see Appendix A. These inconsistencies result in further access inequities and confusion amongst Indigenous people receiving or not receiving variable subsidies based on where they happen to receive care.

Example 2: Section 100 RAAHs Program rules and access to DAAs

The Section 100 RAAHS program rules prevent Indigenous patients from collecting their DAAs from their local DAA packing pharmacies and receiving appropriate counselling by a pharmacist. The Section 100 RAAHS Program rules stipulate that PBS items must be supplied directly by the approved pharmacist or the approved hospital authority, to the participating Aboriginal Health Services (AHS), to be supplied to the patient by a nurse or Aboriginal Health Worker, and not directly to the patient by the supplying pharmacy.

This means that Indigenous patients travelling into rural, regional or urban areas away from where their DAA packing pharmacy is located, are unable to access their DAAs when and where they need them, and receive appropriate counselling by a pharmacist, and must instead travel back to their remote location to collect the DAA from their Section 100 RAAHS. Patients who are accessing healthcare from hospitals in urban, regional, or rural locations may be travelling for several days or weeks before returning to their remote communities. This process is inefficient, not patient-centred and contributes to reduced medicines adherence, and medicines wastage.

Similarly, Indigenous patients requiring DAAs upon discharge from hospital, or after receiving care as day admitted patients, or in an out-patient clinic, are also unable to access DAAs when and where they need them, since Section 94 public and private hospital pharmacy departments are currently unable to participate in the Indigenous DAAs (IDAA) Program. Only Section 90 Pharmacies are eligible to become an Approved Service Provider and participate in the current IDAA Program.

It is clear that these policies contravene government aims to provide care to Indigenous patients that is place-based and person-centred, creating further complexities and barriers to continuity of care and preventative healthcare measures.

Designating a health specific leadership group with diverse representation across the Indigenous health sector and various settings of care, is imperative to developing and implementing polices that meet the healthcare needs of the Indigenous communities.

Information request 2 - Shifting service delivery to Aboriginal community-controlled organisations (ACCOs)

The National Agreement sets specific targets for improving health outcomes for Indigenous Australians, supported by SHPA. Hospitals, pharmacies and ACCHOs are all important in helping achieve these targets by delivering essential healthcare services and contributing to efforts to reduce Indigenous health disparities. Investment in new technologies and expanding access to My Health Record will see future opportunities for more health care to be delivered by ACCHOs.

Expanding the role of ACCHOs

SHPA is broadly supportive of more services being provided by ACCHOs, and Indigenous patients having choice of local and culturally safe healthcare providers. ACCHOs play an important role in supporting their local Aboriginal Torres Strait Islander communities to live better lives and work to meet their unique needs.

SHPA members believe that ACCHOs should aim to provide more holistic and wrap-around care for their communities, including patient-centred pharmacy services and better access to medicines. To support improved medicines adherence and access by Indigenous patients, ACCHOs should have the ability to obtain PBS approval numbers and act as a pharmacy, eligible to dispense PBS medicines to their community.

Pharmacists employed by ACCHOs would facilitate safe and quality use of medicines, improve compliance and support safe transitions of care for Indigenous communities. Integrating pharmacists within Aboriginal Community Controlled Health Services, as recently supported by the Medical Services Advisory Committee (MSAC), would improve chronic disease management. Similarly, employing Transitions of Care Stewardship Pharmacists would ensure that patients discharging from hospital can receive comprehensive medication management support, preventing avoidable hospital re-admissions.

Research indicates that ACCHOs that provide integrated pharmacist access during usual care showed improvements in cardiovascular disease risk factors in Aboriginal and Torres Strait Islander adults with chronic disease, with preliminary reports showing a 34% reduction in the number of hospital admissions, 37% reduction in potentially preventable hospitalisations; 32% reduction in emergency department presentations; and 25% in unplanned admission length of stay.[4]

Information request 11 - Sector-specific accountability mechanisms

SHPA believes that sector-specific accountability mechanisms in Indigenous pharmacy programs could be improved through consideration of creating roles such as a National Indigenous Health Commissioner and Chief Pharmacist at the Commonwealth level. Currently, Associate Professor Dr Faye McMillan AM is the Deputy National Rural Health Commissioner – Allied Health and Indigenous Health, which is an appointment SHPA strongly supports. However, it appears their role is limited to the rural setting, providing advice to the National Rural Health Commissioner on improving access to health services for Aboriginal and Torres Strait Islander people.

SHPA believes these types of roles should be strengthened to be used as an accountability mechanism, to ensure Federal policy objectives, such as the National Medicines Policy (NMP), is being achieved for Indigenous Australians, and that policies and programs, such as the CTG PBS Co-payment Program and Section 100 RAAHS program discussed above, are effective in achieving the NMP.

The current design of various policies and programs relating to Indigenous health, as we have explored in this submission, demonstrates there are many shortcomings in the enforcement and accountability of policymakers, regulators and government. For example, the NMP's principles include person-centered, equity and access, partnership-based and shared responsibility. However, the current design and implementation of pharmacy policies and programs do not achieve NMP principles and are known to be longstanding issues.

Due to the policy gaps, various health services around Australia create their own stop-gap policies or programs to cover up the shortcomings of other areas and leads to inconsistent and highly variable healthcare delivery experience for Indigenous patients. This can negatively impact the confidence and trust Indigenous patients have in healthcare services. At the coalface where these stop-gap measures are implemented, in many hospitals, it is unclear who is responsible when policies and procedures are not followed leading to confusion around responsibility between federal and state and territory jurisdictions, hindering consistent implementation and achievement of program objectives.

The establishment of roles such as a National Indigenous Health Commissioner and Chief Pharmacist at the Commonwealth level could also be used as an accountability mechanism ensuring recommendations made to government by various stakeholders that align with the healthcare needs of the Aboriginal and Torres Strait Islander communities inform the development and evaluation of Federal policies and programs.

For example, these roles would ensure MSAC's recent recommendation for integrating pharmacists within Aboriginal Community Controlled Health Services to improve chronic disease management, is funded by the Commonwealth and that the program includes ongoing data collection, and monitoring to ensure targets set forth in the National Agreement are being achieved.

Fundamentally, SHPA supports the development of shared decision-making mechanisms and mutual accountability, between pharmacies, hospitals and ACCHOs, and commitment to achieving real and meaningful outcomes for Indigenous Australians.

Appendix A: CTG PBS Co-payment Program State-by-State Variations

ISSUE: The Commonwealth funded CTG PBS Co-payment Program excludes PBS medications dispensed from public hospitals and S100 Highly Specialised Drugs

ACTION: Enable CTG prescriptions to be dispensed at Section 94 Public Hospital pharmacies

	ACT	NSW	Vic	Qld	SA	NT	WA	Tas
PBS quantities of medications are supplied to Indigenous patients on discharge from public hospitals	✓	✗	✓	✓	✓	✗	✗	✓
Subsidies are available for PBS quantities of medications supplied to Indigenous patients on discharge from public hospitals	✓	✗	✓	✓	✓	✓	✓	✓
	Whilst many public hospitals use their budget to absorb the co-payment costs not funded by the Commonwealth through the CTG PBS Co-payment Program, this places pressure on already overstretched hospital services and does NOT contribute to patient's safety net.							
The **Federal Government subsidises the PBS co-payment** for Indigenous patients needing medications upon discharge from public hospitals	✗	✗	✗	✗	✗	✗	✗	✗
All Indigenous patients discharging from any hospital in the State/Territory have the **same access to discharge medications**	✓	✗	✗	✗	✓	✗	✗	✓

References

[1] Australian Institute of Health and Welfare (2020) *Indigenous health and wellbeing*, AIHW, Australian Government

[2] Cass A, Lowell A, Christie M, Snelling PL, Flack M, Marrnganyin B et al. (2002) Sharing the true stories: improving communication between Aboriginal patients and health care workers. Med J Aust, 176(10):466- 470. 2 Fallis BA, Dhalla IA, Klemensberg J, Bell CM (2013) Primary Medication Non-Adherence after Discharge from a General Internal Medicine Service. PLoS ONE 8(5): e61735.

[3] Fallis BA, Dhalla IA, Klemensberg J, Bell CM (2013) Primary Medication Non-Adherence after Discharge from a General Internal Medicine Service. PLoS ONE 8(5): e61735.

[4] Couzos S, Smith D, Biros E. (2020) Integrated pharmacists in ACCHSs- Analysis of the assessment of clinical endpoints in Aboriginal and Torres Strait Islander patients with chronic disease (IPAC study). Draft Report to the PSA.