NATIONAL RURAL HEALTH ALLIANCE INC.

# Submission to the Review of Pharmacy Remuneration and Regulation

## September 2016

*This Submission is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies.*

**Good health and wellbeing for rural and remote Australia**

## INTRODUCTION

This Submission has been developed to provide the Review Panel with information for consideration as part of its Review into Pharmacy Remuneration and Regulation, including the challenges of delivering pharmacy services in rural and remote Australia.

The Alliance will not specifically address the five themes and 132 questions posed by the Discussion Paper. This decision was reached with thought to the capacity and expertise of the Alliance in supporting health services in rural and remote Australia.

This Submission is therefore from the perspective of the Alliance as an organisation committed to improving the health and wellbeing of people living in rural and remote Australia[1]. In Australia some seven million people - one third of the population - live outside major cities. Key issues in rural and remote pharmaceutical health care are:

- The health profile of people living in rural and remote Australia is worse than the health profile of people living in the major cities.
- The health profile of Aboriginal and Torres Strait Islander people living in rural and remote Australia is significantly worse than that of non-Indigenous people.
- Access to health care services, including to pharmacy services, in rural and remote Australia is significantly more limited than access to health services in major cities.
- There is a maldistribution of the health workforce, including pharmacists, in Australia strongly skewed in favour of the major cities. Private sector market failure is a common theme for private sector health services in rural and remote Australia due to the lack of critical mass in population and the higher cost in delivering services.
- The use of e-Health in delivering pharmaceutical services has not been fully explored and could provide greater access to pharmacist advice in rural and remote communities.
- Travel distance to services, including pharmacy services, and out of pocket costs are barriers to timely access to health services for people living in rural and remote Australia.

The Alliance defines equity of service as patients having the same access to services in rural and remote Australia as in major cities. Compared with those who live in the major cities, people in Australia's rural and remote areas have reduced access to prescribed and non-prescribed medicines, less advice about the use of medicines and poorer access to professional pharmacy services.[2] As with so many other issues in the rural and remote health sector, there is a gradient of deficit as one moves from major cities through regional areas to remote and very remote places.

The Alliance advocates for the access and supply of both medicines and the professional services necessary for their safe and effective use to be equivalent in rural and remote areas to that in major cities, acknowledging that models will need to be different to ensure such access and supply.

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[1] ABS 2014-15 Publication 3218.0 Regional Population Growth Australia
http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3218.02014-15?OpenDocument

[2] As evidenced by the substantially lower prevalence of pharmacists working in, and the lower PBS expenditure on people living in rural and remote areas.

The National Rural Health Alliance is able to provide any further information that the Review Panel may find helpful in considering this important issue.

## PROVISION OF PHARMACY SERVICES IN RURAL AND REMOTE AUSTRALIA

The Australian Government has a key role in ensuring that medicines, and advice to ensure their safe and effective use, are available to all Australians. Through the Pharmaceutical Benefits Scheme (PBS), the Australian Government subsides the purchase cost, distribution and dispensing of medicines to make them more affordable to people throughout Australia.

As an Australian Government Scheme, the PBS primarily focuses on the provision of medications to community based patients. State and Territory Governments remain responsible for the provision of medications in hospitals.

Since 1990 the Australian Government has entered into successive five year agreements with the Pharmacy Guild, representing the majority of pharmacists approved to supply PBS subsidised medicines in Australia. While the main purpose of these Community Pharmacy Agreements has been to set out the remuneration arrangements for pharmacists, their scope also covers government funded professional programs and a funding pool for pharmaceutical wholesalers.

It has been well established that people living in rural and remote Australia have higher prevalence of illness and chronic disease and poorer health outcomes than their city counterparts. While rates of ill health are higher in rural and remote Australia than in major cities, it is difficult to determine whether the supply of medication is adequate to meet these needs.

The great majority of medications are provided to patients in community settings through community pharmacies.

Approximately 15% of the total 5, 511 community pharmacies across Australia are located within Categories 2-6 (rural and remote) of the Pharmacy Access/Remoteness Index of Australia (PhARIA)[3]. Therefore 85% of community pharmacies are located in PhARIA 1 – Highly Accessible. This illustrates a key focus of pharmacy services and community pharmacists in metropolitan areas and large regional centres. This situation has a flow-on impact on the access to medications.

There is evidence of probable lower levels of access to pharmaceuticals for people living outside Major cities, but the publicly available recent data are insufficient to clearly quantify the extent. The Alliance would strongly suggest that the Government carefully investigate the levels of access to pharmaceuticals and to professional advice and review of pharmaceuticals for people living in rural and remote areas. A comparative analysis of the best practice utilisation of pharmaceuticals for this population, which is known to carry a significant chronic disease burden, compared with the actual utilisation will allow a quantification of the under-

[3] https://www.guild.org.au/issues-resources/rural-and-indigenous-health-policy sighted 12/9/16

utilisation of pharmaceuticals in rural and remote Australia and inform policy changes that could address the under-utilisation by a significant proportion of the population.

**Role of Community Pharmacies**

Community pharmacies provide a range of services including dispensing PBS prescription medication, provision of over-the-counter medication, non-PBSs (or private medication), compounding medications as well as advice on the safe and effective use of medications and some advice around management of illness/injury.

There is huge variability in the services that are provided by pharmacists and pharmacies across Australia and equally there can be varying emphasis on different services. For example, some pharmacies, particularly smaller, suburban pharmacies focus primarily on dispensing medication, providing advice on safe use of medications as well as reviewing and monitoring the use of medication while other much larger pharmacies devote a much larger floor space to commercial retail activities. In rural and remote Australia smaller pharmacies that focus on dispensing medication (and related activities) are most common. Many pharmacies continue to have small retail spaces.

Community pharmacy and pharmacists play a key role in primary health care in Australia through the delivery of PBS medicines and other medicines related services to the community. Community pharmacies in some instances may be considered the most accessed of all health services with Australians visiting pharmacies on average 14 times per year[4].

This is often the case in rural and remote Australia where there are very limited health services available. Consumers in these communities may come to rely on their local pharmacist to provide advice and support when they are unwell. Communities value their local pharmacists as a trusted 'first point of call' particularly when no other primary care service is readily available. Further, pharmacists are very much trusted and respected in rural and remote Australia and often having a local community pharmacy within a rural or remote town is seen as a great advantage to the community.

**Other Community Pharmacy Programs**

Under the Community Pharmacy Agreements other payments can be made to eligible pharmacies for specific Programs. The Program of particular interest to rural and remote Australia is the Rural Pharmacy Maintenance Allowance which is intended to support rural pharmacies that may otherwise be uneconomical to operate. The allowance paid each month to eligible rural and remote proprietors.

The level of support is based on a sliding scale reflecting the number of scripts filled per annum as well as the rurality of the practice and its physical isolation from other pharmacies (using the PhARIA – Pharmacy ARIA). The more remote the pharmacy and the fewer scripts filled, the larger the payment, up to a maximum annual payment of $45,930. This funding represents a small portion of the annual average turnover for a rural or remote pharmacy. It is unknown whether this Allowance offers significant assistance to rural pharmacy or whether it is affecting the sustainability of rural and remote pharmacies.

[4] Review of Pharmacy Remuneration and Regulation Discussion Paper July 2016

Further evaluation of this Program is recommended to determine its effectiveness. Such Evaluation should also consider the appropriateness of the PhARIA remoteness classification and whether it should be transitioned to more robust remoteness measures, such as ASGC-RA or the Modified Monash Model.

There are a number of other programs funded under the Community Pharmacy Agreement that primarily offer workforce support including the Emergency Locum Service, the Rural Intern Training Allowance as well as the Rural Pharmacy Scholarship Scheme. All seek to attract, recruit and retain pharmacists to rural and remote Australia. Similar health workforce programs are currently managed by the Rural Workforce Agencies. There is potential for integration of these programs into the existing capacity and offerings by Rural Workforce Agencies, recognising the interrelationships amongst the various health professionals in rural and remote communities.

Reimbursement through the PBS is not the only means by which the Australian Government funds access to medicines. The other reimbursement mechanisms include the Repatriation Pharmaceutical Benefits Scheme (RPBS), Section 100 medicine provision under the *National Health Act 1953*, and supply through public hospitals which is funded by the relevant jurisdiction. In addition, consumers can and do access medicines through private prescriptions and private purchases from within and outside Australia.[5]

The proportional contribution of these non-PBS sources to total access to medicines is currently not clear. From the perspective of rural and remote patients, the issue is whether their total access, through all means, reflects a deficit situation for PBS medicines compared with metropolitan dwelling Australians.

Of particular relevance to rural and remote Australia is the s100 Remote Area Aboriginal Health Service Program, which enables access to PBS under special supply arrangements for Aboriginal and Torres Strait Islander people living in remote areas at no cost. Under this arrangement remote Aboriginal Health Services are supplied with medicines in bulk to dispense to patients as required under the supervision of a qualified health professional (who is not a pharmacist). This enables relevant medications to be provided at no cost at the time of a consultation, improving access for this high need group.

**Key issues for consideration**

1. Access to health services – including pharmacy services - in rural and remote Australia is much lower than in major cities
2. Rural and Remote Australians, on average, have poorer health than their urban counterparts
3. While robust and reliable data around the rate of PBS prescribing and dispensing is not available, it appears that the rate per capita may be lower in rural and remote Australia than in major cities despite the poorer health status of people living in rural and remote Australia
4. Improved access to data would assist the Alliance and other policy analysts to make more evidence-based analysis and recommendations.

[5] There are strict laws regarding ordering prescription medicines for supply from outside Australia.

## CHALLENGES OF DELIVERING PHARMACY SERVICES IN RURAL AND REMOTE AUSTRALIA

### Access to medication

Attracting and retaining pharmacists to rural and remote Australia is not dissimilar to attracting other health professionals to rural and remote practice.

Establishing a community pharmacy can be a costly exercise and the ongoing financial viability of the business in small rural or remote communities can be questionable.

In many rural and remote locations throughout Australia very few if any health services are available. Where health services do exist there may be a solo GP with some nursing assistance and in very remote small towns the health clinic may be operated by a remote area nurse. Patients have little or no choice of health provider and are not able to select from a range of providers based on their personal needs.

This is also the case with the provision of pharmacy services. Across Australia, they are 425 local communities that have just a single pharmacy in their town[6], and as such, no option for a patient to choose where to seek advice or medication management and review .

It is unknown how many communities do not have even a single pharmacy in the town and therefore have to travel at their own expense to access pharmacy services. In very isolated, remote areas where populations are dispersed, there may be very poor access to pharmacy services with people travelling vast distances to access these services.

Access to PBS medicines is dependent upon access to a person authorised to prescribe medicines through the PBS and generally to a pharmacy authorised to dispense medicines through the PBS. With the significantly lower number per capita of medical practitioners, as well as the few pharmacists in rural and remote Australia, this dilemma is the crux of the fundamental issue of access to medication.

In the most recent Report on Government Services, the Productivity Commission published details of relative access to pharmacy services. Productivity Commission comparisons showed relatively similar numbers of people for every pharmacy across all PhARIA categories, with higher levels of access through Aboriginal Health Services in the most remote PhARIA areas. While the number of people per pharmacy is reasonably similar across PhARIA categories the total number of pharmacies is much lower. This is as expected given the smaller population size, however it does impact dramatically on the availability of pharmacy services. People in rural and remote Australia may have to travel large distances to access a 'local' pharmacy.

The Alliance suggests the need to consider the use of e-Health or Telehealth to support medication review and other pharmacist advisory services in rural and remote communities that do not have access to a pharmacy. Such technological support would also be useful to support s100 providers and their patients.

The delivery of fly in fly out pharmacy services may also support better primary health care patient outcomes, but may require legislative change to be feasible.

[6] https://www.guild.org.au/issues-resources/rural-and-indigenous-health-policy sighted 12/9/16

**Table 1: Approved providers of PBS medicines by PhARIA area at 30 June 2015**

| | *PhARIA1* | *PhARIA2* | *PhARIA3* | *PhARIA4* | *PhARIA5* | *PhARIA6* | *Total* |
|---|---|---|---|---|---|---|---|
| Derived population (millions) | 18.17 | 0.78 | 1.24 | 0.49 | 0.46 | 0.31 | 21.46 |
| People per pharmacy | 3933 | 4239 | 3628 | 3589 | 3101 | 3943 | n.p. |
| People per approved provider (excl hospitals) | 3932 | 4193 | 3606 | 3512 | 2655 | 1355 | 3769 |
| Number of pharmacies | 4620 | 185 | 342 | 137 | 149 | 78 | 5511 |
| Number of approved GPs | 0 | 0 | 0 | 3 | 10 | 8 | 21 |
| Number of public hospitals | 111 | 12 | 18 | 5 | 6 | 9 | 161 |
| Number of private hospitals | 115 | 0 | 1 | 0 | 0 | 0 | 116 |
| Number of Aboriginal Medical Services operating under Section 100 of the Act | 2 | 2 | 2 | 0 | 15 | 141 | 162 |
| **Total providers** | **4848** | **199** | **363** | **145** | **180** | **236** | **5971** |

*Source: http://www.pc.gov.au/research/ongoing/report-on-government-services/2016 Table 10A.20*

The same report describes PBS expenditure by ASGC Remoteness. It is difficult to compare Table 1 above to Table 2 below given the different classifications used to describe rural and remote areas, thus making it impossible to comment on the level of expenditure per pharmacy by remoteness.

**Table 2: PBS expenditure per person, by remoteness area (2014-15 dollars), 2014-15**

| | *MC* | *IR* | *OR* | *R* | *VR* | *Australia* |
|---|---|---|---|---|---|---|
| | 2014-15 dollars | | | | | |
| *Total expenditure (millions)* | 4 765.1 | 1 533.8 | 677.1 | 68.1 | 24.3 | 7 071.7 |
| *Annual expenditure per person* | 286.9 | 359.5 | 325.3 | 210.3 | 116.5 | 301.0 |

Source: *: http://www.pc.gov.au/research/ongoing/report-on-government-services/2016 Table 10A.22*[7,8]

Table 2 shows PBS expenditure per capita (including the s100 expenditure noted above) is almost $350 per capita annually in rural/regional areas (see columns IR and OR above), compared with just under $290 per capita in major cities, and around $224 per capita annually in remote Australia.

However, this table provides no information on whether people in rural and remote areas are adequately served in terms of their access to pharmaceuticals. That is, it does not give any information about the need of the population which enables identification of the possible gaps in access to services.

[7] Note that the total expenditure for Australia includes $3 million where the location of the consumer was unknown.

[8] In addition, PBS funded $23.9 million worth of PBS subsidy to 162 Aboriginal Health Services operating under Section 100 which were able to provide medication (of which 156 were operating in remote or very remote areas). This increases the annual PBS expenditure in remote and very remote areas to 116 million (or approximately $224 per person).

We know that people living in rural and remote Australia are, on average, older than their city counterparts, more unwell than their city counterparts and have lower income than their city counterparts. This results in the rural and remote population having a greater need for medications as well as being more likely to have a health care card.

In fact, we know that people in rural and regional Australia are 28% more likely to be health card holders than people in major cities[9].

The Government expenditure (ie the subsidy paid by Government) related to PBS expenditure for health care card holders is significantly higher than for non-card holders and as such we expect to see higher levels of PBS expenditure in rural and remote areas than in major cities to take into account the higher levels of health card holders.

Further, we expect that a health care card holder will also use a greater number of medicines than their non-health care card holder counterparts. So the PBS expenditure is again confounded. As we know rural and regional Australians are 28% more likely to be health care card holders, we would expect data to show a higher PBS expenditure in rural and remote Australia.

However, the data cannot and does not provide any evidence that the rates of medication prescribing to rural and remote communities is adequate or equitable.

The information relating to PBS expenditure is further complicated by the varying costs of medication. This is particularly relevant to the variation in price between generic and branded medication – both with the same efficacy. Often the cost to the consumer of the generic medication is significantly lower than the branded medication. Prices may be below the PBS threshold amount and would therefore not attract a PBS subsidy.

The price charged for medications below the PBS threshold vary from pharmacy to pharmacy. In major cities and large regional centres, where a number of community pharmacies exist consumers have choice around where they purchase their medication – seeking out the lowest cost. In many rural and remote areas, where there is one pharmacy, there is little or no choice around seeking lower cost medication and/or a generic brand. This may impact on the PBS expenditure shown in the Table 2 above.

In summary, while we have data about the average per capita PBS expenditure in rural and remote areas, there is insufficient information, for the reasons outlined above, to determine whether the access to medication is adequate and meeting the needs of rural and remote patients.

**Access to Advice re Medication**

Compared with major cities, the prevalence of pharmacists (as expressed by FTE per 100,000 population) in rural areas is around 80%, and around 60% in remote areas. In addition, the sixth Community Pharmacy Agreement notes that pharmacies outside PhARIA1 (i.e. Outside Highly Accessible areas) have fewer female, and also older and less qualified staff.[10] Fewer and

[9] http://ruralhealth.org.au/book/health-card-holders

[10] http://6cpa.com.au/wp-content/uploads/Reference-data-base-of-Australias-community-pharmacies-analysis-of-national-survey-final-report.pdf

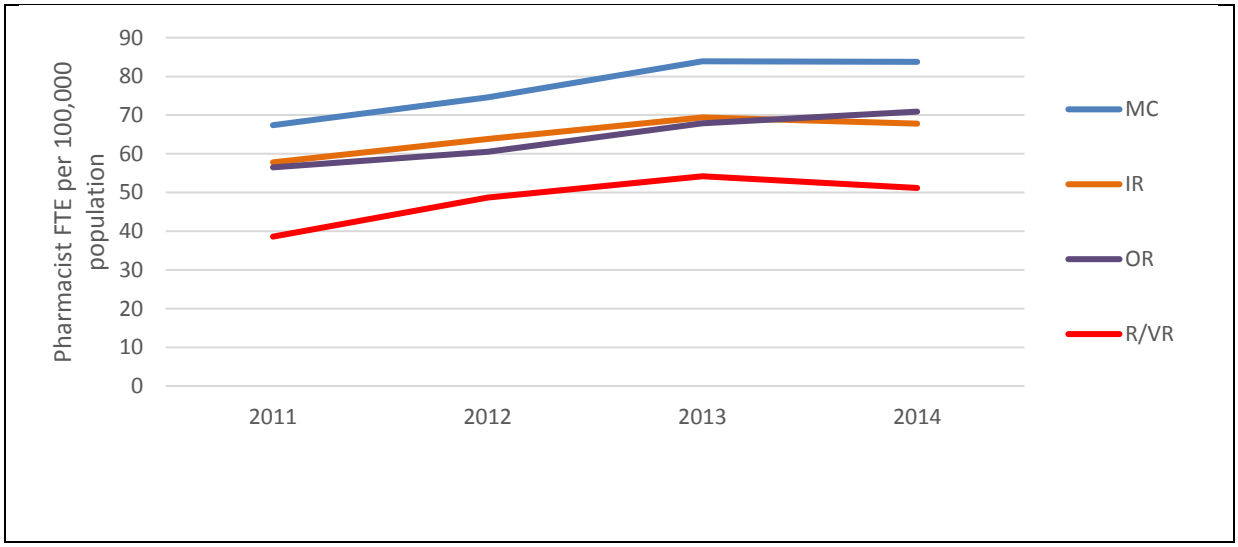
less qualified pharmacists can only mean lower levels of access to important advice re medicines.

**Table 3: Number of Pharmacist Full-time equivalents per 100,000 population, by Remoteness, 2011 to 2014**

| | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|
| | Pharmacist FTEs per 100,000 population | | | |
| **MC** | 67.4 | 74.6 | 83.9 | 83.8 |
| **IR** | 57.8 | 63.8 | 69.4 | 67.8 |
| **OR** | 56.5 | 60.5 | 67.9 | 70.9 |
| **R/VR** | 38.6 | 48.7 | 54.2 | 51.2 |

Source: http://www.aihw.gov.au/workforce/ (dynamic data display)

**Figure 1: Number of Pharmacist Full time equivalents per 100,000 population, by Remoteness, 2011 to 2014**




Source: http://www.aihw.gov.au/workforce/ (dynamic data display)

While this data represents all pharmacists – not only those working in a community pharmacy capacity – they show a clear disparity between major cities and rural and remote areas. People living outside major cities have poorer access to professional advice[11] related to medicines, and this has implications for both the safety of patients and for the effectiveness of medicines.

In addition, access to professional pharmacy services funded by the Australian Government, such as Home Medicine Reviews (HMR), Meds Check and Diabetes Meds Check, Dose Administration Aids, National Diabetes Services Scheme, Opioid Dependence Treatment and Residential Medication Management Reviews (RMMR), is often limited in rural Australia and frequently unavailable in remote communities.

Under Section 100, medicines are supplied in bulk to remote Aboriginal Health Services but, under the arrangement, the services of a pharmacist are generally not available to then dispense medicines to the patient. Consequently, the medicines may not be labelled (or recorded in the consumer's health record), and the patient may not receive any advice about

[11] As evidenced by the lower prevalence of pharmacists in these areas.

the medicine (including contraindications) or an ongoing review of its efficacy - all normal services available when medicines are obtained from a community pharmacist.

**Impact of poor health literacy**

Anecdotal evidence suggests that there may be some confusion or lack of clarity by consumers relating to the range of services that pharmacists have the skills and experience to provide, including medication review and monitoring, advice on appropriate over the counter medication or complementary therapies, as well as illness and injury management. This may indicate a need for clearer communication to consumers through a marketing campaign or other similar avenues. Further to this lack of clarity, there is also limited understanding of how these services that are provided by pharmacists are remunerated.

In rural and remote areas, these 'additional services' provided by pharmacist are vital to consumers as there may be few other health providers (and those available may have significant waiting times) to give this level of support and guidance.

We also know that health literacy can be much lower in rural and remote Australia and this effects an individual's ability to access and understand complex information. People living in rural and remote Australia can have lower levels of health literacy, which not only compromises their ability to exercise informed choice, but exposes them to higher risks of adverse outcomes[12]. This is particularly concerning where the adverse outcomes from the incorrect use of medicines can be detrimental.

Many rural and remote Australians have no direct access to pharmacists or pharmacy services. In rural and remote areas, it is not always viable to have a community pharmacy. In these areas we must ensure that there is adequate access to medicines and advice relating to the safe and appropriate use of medications. One area that has not been explored is to what extent could e-Health be used within pharmacy services to support remote patients, and what payment mechanisms would be needed to facilitate this access.

**Key issues for consideration**

1. People living in rural and remote Australia have poorer access to information relating to the safe and effective use of pharmaceutical medication.
2. Medications generally contribute to improving ill-health and maintaining good health and wellbeing, however where limited or no information is provided around the safe use of medication, it can result in harm or illness to a patient.
3. This situation is exacerbated by the often poor health literacy of people living in rural and remote Australia.

[12] Australian Institute of Health and Welfare 2012. Australia's health 2012. Australia's health series no.13. Cat. no. AUS 156. Canberra: AIHW; at 182

**INCREASING ACCESS TO PHARMACY SERVICES IN RURAL AND REMOTE AUSTRALIA**

***Pharmacists as part of the Primary Care team***

The National Rural Health Alliance sees pharmacists as a key member of a primary health care team and as such, pharmacists should have a broader role in providing primary care type services to consumers. The specific details about appropriate services would need to be determined in consultation with other health professionals, but the Alliance suggests that it would be appropriate to consider better using the skills of pharmacists to provide:

- Vaccinations (including those included on the Childhood Immunisation Register)
- Chronic Disease (including mental health) Management and Coordination of health services
- Health Checks and Screening
- Wound Management
- Medication review
- Management of minor ailments

It would be vital to identify the most appropriate remuneration model for these services. Currently, the Medicare system does not enable remuneration of pharmacists, however the infrastructure supporting the Medicare payment system could be upgraded to include pharmacists. Alternatively, a similar but parallel system for pharmacy services could be considered. Engaging and remunerating pharmacists to undertake these services could free up GPs and other medical practitioners to focus on more complex roles and enhance patient access to health professional advice and support.

Having the pharmacist provide these services as outlined above would need to be supported by a sophisticated system of record sharing with the GP and other health providers involved in the patients' care. Current systems of electronically controlled patient records appear to be progressing to a point that they would support this model of 'shared care'.

Further the Alliance believes that pharmacists, as a key part of the primary health care team, should be embedded in rural and remote health service delivery. Models should be explored where a pharmacist works within a primary health care centre (including general practice, Aboriginal Health Service or other similar service). This would offer an enhanced skills mix and enable patients to have thorough review and monitoring of medications.

In terms of funding models, while it may be cost prohibitive for rural general practices to employ a pharmacist in a full time capacity, it may be possible for the pharmacist to be shared across practices or to be employed by the primary care network and 'shared' across a regional area. Whilst not ideal in terms of ongoing on-the-ground care, including pharmacists in outreach programs -whether they be fly-in-fly-out or allied health outreach programs. would be beneficial for communities.

***Location Rules***

The location of community pharmacies in Australia is determined through the application of pharmacy location rules. These rules restrict where an approved pharmacy can be located and aim to ensure a well-distributed network of community pharmacies to provide medications to all Australians – including in rural and remote areas.

In many small rural and remote towns and cities across Australia, there are few pharmacies and pharmacists. In some instances, there would be only one pharmacy within a town. While removing location rules may increase choice to the consumers within the town by allowing additional pharmacies to operate it could be detrimental to the ongoing viability of pharmacy services within the town. That is, the town would not be able to financially support more than one pharmacy.

On balance, the Alliance suggests location rules remain in rural and remote Australia to assist with the viability of community pharmacy services in small rural and remote communities. Any modifications to the location rules in these areas should be undertaken with close consideration to the adverse impacts it may have on service viability and sustainability.

***Complementary Medicines***

Many pharmacies stock and sell complementary medicines. These medicines include vitamin, mineral, herbal, aromatherapy and homoeopathic products. While these products are regulated through the Australian Government by the Therapeutic Goods Administration the evidence base for their use remains equivocal. This Review poses a question regarding whether these products should be provided within a community pharmacy setting where consumers may assume a level of effectiveness and efficacy by virtue of the items being available from a reputable and trusted supplier.

The Alliance believes that it remains appropriate for these items to be available in community pharmacy settings provided that the evidence (or lack of evidence) is clearly communicated to the consumer by the pharmacist or other adequately trained staff. By having such items available within a structured setting where there is opportunity for information, discussion and advice by a skilled expert means that patients can make an informed decision about use of these items, other more beneficial options, as well as possible interactions with prescription or over the counter medication.

These products remain available in many supermarkets and health food stores where this level of advice and support may not be available. Removing these complementary medicines from circulation within a community pharmacy would have little or no benefit to consumers and may in fact increase risk as consumers would still be able to purchase these items but with little or no access to advice and information.

***E-Pharmacy***

When medication is dispensed it is vital that the consumer is provided with information and advice around its safe and effective use.

In some rural and remote parts of Australia, consumers are not able to access a pharmacist or pharmacy. As such, prescription medications may be provided through some alternative programs including S100 arrangements, doctor bags, or Royal Flying Doctor medications. These medications are provided by a health practitioner without a consumer having direct access to advice and information from a pharmacist.

In this instance it would be beneficial for a consumer to have access to a pharmacist via email or telephone. This would enable important information about the medication and its safe use to be communicated directly to the consumer.

Further, in instances where other dispensing arrangements are not available, a patient may be able to provide their script to a remotely located pharmacy perhaps in a regional centre (via post, email etc) to dispense and post to them with follow up telephone, email, skype support from the pharmacy. This would remove the requirement for the patient to travel to the pharmacy which may be some distance from their home.

Currently scripts must be provided in hard copy to the pharmacist for dispensing, however with advancement in technology, it would be useful to consider other alternatives to enable greater flexibility in servicing rural and remote Australia.

**Key issues for consideration**

1. Governments play a vital role in funding and delivering health care services in rural and especially remote Australia.
2. Without government action – including pharmacy location rules – there would be no services in many rural and remote communities due to the challenges of establishing and maintaining a sustainable pharmacy.
3. The scope of practice for pharmacists, particularly those working in rural and remote Australia, could be expanded to help address broader issues of workforce shortage and to strengthen primary health care teams.
4. Improved access to technology – including in rural and remote Australia – gives rise to greater consideration of e-Pharmacy services both around dispensing as well as providing advice, review and monitoring of medication usage.

**ATTACHMENT A**

## ABOUT THE NATIONAL RURAL HEALTH ALLIANCE

The National Rural Health Alliance (the Alliance) is comprised of 38 national organisations (see Attachment A). The Alliance is committed to improving the health and wellbeing of the more than 6.9 million people living in rural and remote Australia[13].

Alliance members include consumer groups (such as the Country Women's Association of Australia), representation from the Aboriginal and Torres Strait Islander health sector, health professional organisations (representing doctors, nurses and midwives, allied health professionals, dentists, pharmacists, optometrists, paramedics, health students, chiropractors and health service managers) and service providers (such as the Royal Flying Doctor Service).

The Alliance's vision is good health and wellbeing in rural and remote Australia. Our member organisations are committed to working towards equitable health care services and health outcomes in rural and remote Australia. The member bodies bring knowledge of specific priority areas across the different agencies.

The Alliance views health care as a universal right and works to ensure that all Australians can receive high quality, affordable health care within a reasonable distance of their home, their family and their community.

### Member Bodies of the National Rural Health Alliance

ACEM-RRRC - Australasian College for Emergency Medicine's Rural, Regional and Remote Committee
ACHSM - Australasian College of Health Service Management (rural members)
ACM-RRAC - Australian College of Midwives Rural and Remote Advisory Committee
ACN-RN&MCI - Australian College of Nursing (Rural Nursing and Midwifery Community of Interest)
ACRRM - Australian College of Rural and Remote Medicine
AGPN - Australian General Practice Network
AHHA - Australian Healthcare and Hospitals Association
AHPARR - Allied Health Professions Australia Rural and Remote
AIDA - Australian Indigenous Doctors' Association
ANMF - Australian Nursing and Midwifery Federation (rural nursing and midwifery members)
APA (RMN) - Australian Physiotherapy Association (Rural Members Network)
APS - Australian Paediatric Society
APS (RRPIG) - Australian Psychological Society (Rural and Remote Psychology Interest Group)
ARHEN - Australian Rural Health Education Network Limited
CAA (RRG) - Council of Ambulance Authorities (Rural and Remote Group)
CATSINaM - Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
CRANAplus - the professional body for all remote health
CWAA - Country Women's Association of Australia
ESSA (RRIG) - Exercise and Sports Science Australia (Rural and Remote Interest Group)
FRAME - Federation of Rural Australian Medical Educators

[13] ABS 2014-15 Publication 3218.0 Regional Population Growth Australia
http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3218.02014-15?OpenDocument

HCRRA - Health Consumers of Rural and Remote Australia
IAHA - Indigenous Allied Health Australia
ICPA - Isolated Children's Parents' Association
NACCHO - National Aboriginal Community Controlled Health Organisation
NATSIHWA - National Aboriginal and Torres Strait Islander Health Worker Association
NRHSN - National Rural Health Students' Network
PA (RRSIG) - Paramedics Australasia (Rural and Remote Special Interest Group)
PSA (RSIG) - Rural Special Interest Group of Pharmaceutical Society of Australia
RACGP Rural: The Royal Australian College of General Practitioners
RDAA - Rural Doctors' Association of Australia
RDN of ADA - Rural Dentists' Network of the Australian Dental Association
RFDS - Australian Council of the Royal Flying Doctor Service
RHWA - Rural Health Workforce Australia
RIHG of CAA - Rural and Indigenous Health-interest Group of the Chiropractors' Association of Australia
ROG of OA - Rural Optometry Group of Optometry Australia
RPA - Rural Pharmacists Australia
SARRAH - Services for Australian Rural and Remote Allied Health
SPA-RRMC - Speech Pathology Australia - Rural and Remote Member Community

**Rural and remote demography and socio-economic status**

Using 2015 estimates, the Australian Bureau of Statistics estimates that in total, 70% of Australians live in major cities, while 30% - that is 6.9 million people – live in regional (including rural) or remote areas (27.5% of Australians live in regional areas, while 2.5% live in remote areas)[14].

Compared with major cities:

- Rural (including regional) populations have proportionally more children, fewer young adults, fewer people of working age, more people in late working age approaching retirement, and more elderly people.
- Remote populations have proportionally more children, fewer young adults, slightly more people of working age, similar numbers of people in late working age approaching retirement, and substantially fewer elderly people.

The geographic distribution of the Aboriginal and Torres Strait Islander population varies greatly from the non-Indigenous population. While only 1% of the population in major cities is Aboriginal or Torres Strait Islander, they make up 45% of the population in very remote areas[15]. Approximately 35% of Australia's Aboriginal and Torres Strait Islander people live in major cities, with 65% living in regional and remote areas. In comparison, 71% of Australia's non-Indigenous people live in major cities, and 29% live in regional or remote areas.

The Aboriginal and Torres Strait Islander population shows a young population with approximately 42 percent under working age and less than 50 percent of working age (aged 20-59) compared with an older profile in the non-Indigenous population with approximately 26 percent under working age and over 56 percent of working age (aged 20-59).

**The social determinants of health**

The Alliance undertakes its policy work within the framework of the social determinants of health, which are those underlying features of society and community that affect an individual's ability to achieve personal good health and wellbeing. For example, housing, education, access to healthy food, and employment. These underpin the essence of good health and wellbeing. Where these factors are not successfully addressed, good health and wellbeing may be difficult to attain.

The Alliance Fact Sheet on the social determinants of health and the way in which they influence health and wellbeing in rural and remote Australia is at http://ruralhealth.org.au/advocacy/current-focus-areas/social-determinants-health .

[14] ABS 2014-15 Publication 3218.0 Regional Population Growth Australia http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3218.02014-15?OpenDocument

[15] Throughout this submission references to remoteness areas are based on ASGC-RA, in which category 1 is Major cities, 2 is Inner regional areas, 3 Outer regional, 4 Remote and 5 Very remote. For methodological reasons (eg small numbers) Remote and Very remote are often reported jointly. In the submission, references to "regional areas" mean Inner plus Outer regional; and references to "remote areas" mean Remote plus Very remote.

**Health in rural and remote Australia**

The health of people living in rural and remote Australia is poor when compared with the health of people living in major urban centres[16].

On average, people who live in rural and remote Australia do not enjoy the same high standard of health and wellbeing as those who live in the cities, or the same access to health services and health-related infrastructure. The differentials are particularly stark for Aboriginal and Torres Strait Islander people. There are a range of issues involved and it is the rural and remote people themselves who are best placed to understand the issues and to generate and manage solutions.

Compared with major cities, the burden of disease is 9 per cent higher in rural areas and 26 per cent higher in remote areas[17]. The fatal health burden increases with remoteness by at least 50 per cent for Aboriginal and Torres Strait Islander Australians and by up to 20 per cent for non-Indigenous Australians[18]. Most chronic diseases have a higher prevalence in rural areas. For example, compared with the major cities:

- the prevalence of cardiovascular disease is approximately 7 per cent higher;[19]
- the incidence of bowel cancer and lung cancer in rural and remote areas is 15 per cent and 10 to 50 per cent higher respectively, while the incidence of melanoma is 20 per cent higher in rural areas[20];
- the incidence of end-stage kidney disease is roughly similar or slightly higher in rural areas, but much higher in remote areas, reflecting very high incidence among Aboriginal and Torres Strait Islander people;[21]
- the prevalence of type 2 diabetes in rural areas is roughly similar, or possibly slightly higher;
- the prevalence of arthritis is about 8 per cent higher in rural areas;[11]
- the prevalence of mental illness in rural areas is similar or slightly higher.[22]

In rural communities the health effects of the disadvantage is compounded by poor access to communications (such as high speed broadband and mobile phone coverage), public transport and environmental challenges (such as drought, floods and bushfire). Simply being unable to leave the family farm for a period to seek medical attention is a significant barrier to seeking

[16] http://ruralhealth.org.au/book/health-status-and-outcomes
[17] AIHW, http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442459747
[18] AIHW, http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129550616
[19] PHIDU, http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-Australia-remoteness=areas
[20] http://pandora.nla.gov.au/pan/146265/20140703-0935/www.coagreformcouncil.gov.au/reports/healthcare/healthcare-australia-2012-13-five-years-performance.html
[21] http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129549614
[22] http://pandora.nla.gov.au/pan/146265/20140703-0935/www.coagreformcouncil.gov.au/reports/healthcare/healthcare-australia-2012-13-five-years-performance.html

timely health care, as are the distances that may need to be travelled, the out of pocket costs and the time away from the community[23,24].

**Aboriginal and Torres Strait Islander health care and services**

The prevalence of chronic disease among Aboriginal and Torres Strait Islander Australians is frequently greater than among non-Indigenous people, with the incidence of chronic disease increasing with remoteness.

- Aboriginal and Torres Strait Islander Australians in rural areas are about 25 per cent more likely to have diabetes, while those in remote areas are more than twice as likely (ie 100%) to have diabetes;[25] than in major cities and
- the incidence of end-stage kidney disease is twice as high amongst Aboriginal and Torres Strait Islander Australians from Outer regional areas, and about four times as high amongst Aboriginal and Torres Strait Islander Australians from remote areas than in major cities.[26]
- Aboriginal and Torres Strait Islander Australians in remote areas are also 60 per cent more likely to have circulatory disease compared with those in major city and rural areas.[27]

There is also evidence that the social determinants of health have a greater impact on Indigenous Australians as remoteness increases. Employment and incomes for Indigenous people tend to be lower in more remote areas than in major cities. Again, this impacts on the ability of Indigenous people to access health and other human services.

**Health expenditure by remoteness**

The AIHW report , *Australian health expenditure by remoteness* (2011) shows that people in rural and remote Australia have substantially less equitable access to health services. In particular, they have a low share of government outlays on primary care, diagnostic, specialist services and other out of hospital services; and non-acute hospital care and same-day hospital services.

The one third of the population who live outside the major cities have the highest health care needs, but also the worst access to health services. The difficulty accessing health services means poorer management of illness. The result of this is increased rates of ill health, hospitalisation and premature death in our rural and remote population.
There is a $2 billion deficit in Medicare expenditure in rural and remote Australia when compared with the same population in major cities. This is primarily attributable to the lack of services available to the population."

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[23] Barriers to accessing rural paediatric speech pathology services: Health care consumers' perspectives, Anna M. O'Callaghan*, Lindy McAllister and Linda Wilson, AJRH, 13: 3, pp162-171, June 2005

[24] Understanding barriers to health care: A review of disparities in health care services among Indigenous populations, Sonia Marrone, International Journal of Circumpolar Health 66:3 pp188-198, 2007

[25] http://www.dpmc.gov.au/indigenous-affairs/publication/aboriginal-and-torres-strait-islander-health-performance-framework-2014-report

[26] http://www.dpmc.gov.au/indigenous-affairs/publication/aboriginal-and-torres-strait-islander-health-performance-framework-2014-report

[27] http://www.dpmc.gov.au/indigenous-affairs/publication/aboriginal-and-torres-strait-islander-health-performance-framework-2014-report

The Alliance has developed a Fact Sheet on this issue, which is available at http://ruralhealth.org.au/sites/default/files/publications/fact-sheet-27-election2016-13-may-2016.pdf .

**Health workforce**

At least in part, some of the reason for the $2 billion deficit on health expenditure in rural and remote Australia is due to health workforce shortages. Despite a range of government programs to attract general practitioners, dentists and other health practitioners to rural and remote practice over many years, the ongoing shortages represent a significant barrier to addressing the health inequalities present in rural and remote Australia.

According to data from the Australian Institute of Health and Welfare (AIHW), the number of full-time equivalent (FTE) medical practitioners per head declines substantially the further you travel away from major cities. There are, for example, 405 medical practitioners per 100,000 people in major cities, but only 275 in inner regional areas, 250 in outer regional areas, and 249 in remote and very remote areas.[28] Similar trends are seen in the supply of dental health professionals and allied health professionals (who include physiotherapists, psychologists and optometrists).[29] The supply of nurses and midwives per head is lower in regional areas than major cities, but is slightly higher in remote and very remote areas.[30]

[28] AIHW 2014.Medical Workforce 2012.National health workforce series no. 8. Cat. no. HWL 54. Canberra: AIHW.http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129546076

[29] AIHW 2014. Dental workforce 2012.National health workforce series no. 7. Cat. no. HWL 53. Canberra: AIHW.http://www.aihw.gov.au/publication-detail/?id=60129545961

Allied Health: AIHW 2013. Allied health workforce 2012.National health workforce series no. 5. Cat. no. HWL 51. Canberra: AIHW.
http://www.aihw.gov.au/publication-detail/?id=60129544591

[30] AIHW 2013. Nursing and midwifery workforce 2012.National Health Workforce Series no. 6. Cat. no. HWL 52. Canberra: AIHW.http://www.aihw.gov.au/publication-detail/?id=60129545333