Submission No 46

INQUIRY INTO OVERCOMING INDIGENOUS DISADVANTAGE

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31 January 2008

The Hon Ian West, MLC
Chairperson
Legislative Council Standing Committee on Social issues
NSW Parliament
Macquarie Street
SYDNEY NSW 2000

By email: socialissues@parliament.nsw.gov.au

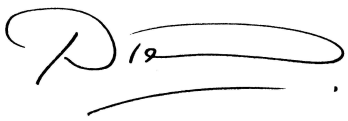
Dear Mr West

Enquiry into The Life Expectancy Gap Between Indigenous and Non-Indigenous Australians

I am pleased to submit for the Standing Committee's consideration a submission from the Pharmaceutical Society of Australia (NSW Branch) Ltd.

We would be happy to provide additional information and present at a public hearing if desired. Please do not hesitate to contact me on (02) 9431 1100.

Yours sincerely



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SUBMISSION

TO THE NSW LEGISLATIVE COUNCIL'S

STANDING COMMITTEE ON SOCIAL ISSUES

ENQUIRY INTO

THE LIFE EXPECTANCY GAP BETWEEN INDIGENOUS AND NON-INDIGENOUS AUSTRALIANS

PHARMACEUTICAL SOCIETY OF AUSTRALIA
(NSW BRANCH) LTD

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The submission was prepared by Ms Maxine Goodman FPS, with advice guidance and support of the members of the Society's Advocacy Committee including Mr John Bell AM, Professor Charlie Benrimoj, Mr Peter Gissing, Mr Ron Natoli, Mr Frank Payne, Mr Warwick Plunkett, Mr Warwick Wilkinson AM, Mr James McGillicuddy and Mr Steven Drew.

The thanks of the Society and the writer also go out to members of the pharmacy profession who gave so generously of their time to share their thoughts, insights and experiences of working with Indigenous Australians including Mr Peter Gissing, Ms Karalyn Huxhagen, Ms Fran Vaughan, as well as those of our members who are quoted but wish to remain anonymous.

We would also like to thank Mr Gerard Stevens, Managing Director of Webstercare for his time and assistance in providing information relating to Dose Administration Aids (DAAs) to support medication adherence in the community.

Finally, our thanks go to the staff of the Society who provided administrative and executive support to this project.

PREFACE

The Pharmaceutical Society of Australia (PSA), as an organisation representing caring primary health care providers, welcomes the initiative of the NSW Government in establishing an enquiry into the life expectancy gap between Indigenous and non-Indigenous Australians. We are pleased to place before this enquiry a submission which outlines how increasing the efficient use of pharmacists and their resources could assist in narrowing this gap.

The Pharmaceutical Society of Australia (NSW Branch) – the Society – is the organisation that professionally represents all pharmacists no matter what their area of employment. Our members work in community pharmacy, hospital pharmacy (both public and private hospitals), academia, the pharmaceutical industry, government (both state and federal) and some other fields. The majority of our members come from the first two areas.

Given their importance, usually as the first point of contact, in a community pharmacy, we have also extended affiliate membership to pharmacy support staff who have appropriate qualifications.

Pharmacists are the only health professionals "in the market place" who most consumers can access without an appointment and at no direct cost. It is estimated that the total population of Australia passes through a community pharmacy once every 6 weeks.

The community continually rates Pharmacy as one of the most ethical and honest professions in Australia yet the professional services that pharmacists can provide to our community are very much under utilised. In particular as community pharmacies are privately owned and therefore do not have a direct connection with the range of health services and health professionals associated with the Department of Health, they are sometimes overlooked in the consideration of the total health care team. The establishment of partnerships with these health professionals and more effective use of a pharmacist's specific expertise will assist in improving the total health of our community.

Currently Pharmacy is either a 4 year undergraduate or 2 year post graduate course plus an 'internship' year prior to registration. Besides studying more pharmacology than students of medicine, modern pharmacists are trained in disease state management, medication reviews, and many aspects of primary health care, all of which provides an outstanding, highly trained though currently significantly underutilised workforce available to improve Indigenous disadvantage.

SUBMISSION

Introduction

During the 20th Century life expectancy for all Australians increased considerably due, in the first instance, to improved sanitation, nutrition and vaccination.

The ABS & AIHW 2005 report indicates that in the period 1996-2001, life expectancy at birth was estimated at 59 years for Indigenous males and 65 years for Indigenous females. These are around 17 years below the life expectancies of 77 years for all Australian males and 82 years for all Australian females in 1998-2000. This is emphasised when we note that the "elderly" category for the Indigenous community commence at 55 years of age, while for the non-Indigenous community such statistics commence at 65 years or older.

According to an Australian Bureau of Statistics (ABS) Report[1]:

- Between 2000 - 2004, the leading causes of death for Indigenous men and women aged 55 years and over were cancer, diseases of the circulatory system, respiratory diseases and diabetes.
- Among Australians aged 55 years and over, mortality rates for diseases of the circulatory system were almost one-and-a-half times higher for Indigenous than non-Indigenous men (1,448 per 100,000 compared with 1,006 per 100,000), and were similar between Indigenous and non-Indigenous women (1,035 per 100,000 compared with 1,016 per 100,000).
- Among Australians aged 55 years and over, mortality rates for diseases of the respiratory system were twice as high for Indigenous than non-Indigenous men (542 per 100,000 compared with 268 per 100,000), and were also higher for Indigenous than non-Indigenous women (349 per 100,000 compared with 212 per 100,000).
- Among Australians aged 55 years and over, death rates for diabetes were six times higher for Indigenous than non-Indigenous men (406 per 100,000 compared with 68 per 100,000), and almost nine times higher for Indigenous than non-Indigenous women (492 per 100,000 compared with 57 per 100,000).
- Among Australians aged 55 years and over, death rates for chronic kidney disease were almost two-and-a-half times higher for Indigenous than non-Indigenous men (97 per 100,000 compared with 41 per 100,000) and more than three times higher for Indigenous than non-Indigenous women (133 per 100,000 compared with 42 per 100,000).

[1] ABS (2007), 4722.0.55.002 - Older Aboriginal and Torres Strait Islander people: A snapshot, 2004-05

- Among Indigenous people who reported their height and weight in 2004-05, 24% of people aged 55 years and over were in the normal/healthy weight range, 34% were overweight and 39% were obese.

- Older Indigenous people were less likely than Indigenous people aged 15-54 years to be in the normal/healthy weight range (24% compared with 40%) and more likely to be in the overweight or obese weight range (74% compared with 54%).

- Among Australians aged 55 years and over, Indigenous people were more likely than non-Indigenous people to be overweight or obese (74% compared with 59%).

- Among Australians aged 55 years and over, Indigenous people were two-and-a-half times as likely as non-Indigenous people to be current daily smokers (30% compared with 12%). It should also be noted 53% of Indigenous people aged 18 to 54 are smokers.

- Among Australians aged 55 years and over in non-remote areas, Indigenous people were significantly more likely than non-Indigenous people to have a disability or long-term health condition (77% compared with 63%).

- Among Australians aged 55 years and over in non-remote areas, Indigenous people were one-and-a-half times as likely as non-Indigenous people to report a profound or severe core activity limitation (15% compared with 10%).

In a separate report commissioned by The Heart Foundation[2], age specific mortality differentials between Indigenous and non Indigenous members of the community are even more alarming as between the ages of 25 – 54, rates of death due to cardio vascular disease in the Indigenous members are between seven and twelve times that of non-Indigenous people.

Despite the almost complete disappearance of Acute Rheumatic Fever (ARF) and Rheumatic Heart Disease (RHD) from much of the industrialised world, these diseases remain important contributors to the suffering experienced by Indigenous Australians.

In remote Aboriginal communities of the Northern Territory, between 1 – 3% of the population has established RHD, due to repeated infections with group A streptococci, subsequent episodes of rheumatic fever and resultant cumulative valve damage.

It is also reported that fewer Indigenous persons living in urban areas receive vaccinations against influenza and pneumonia as those living in rural areas, while those who have employment are healthy than those not working.

The rate of hospitalisation for Indigenous people with circulatory, respiratory, kidney and diabetic diseases is 1.5 to 9 times higher than the rate for non-Indigenous people. One third of all admissions to hospital for Indigenous people relate to kidney disease.

In summary it appears that the factors affecting the health of Indigenous people parallel those affecting the non-Indigenous people, alcohol, smoking, obesity, low rates of vaccination, lack of

[2] Brown, A (2007), Ensuring the Quality Use of Medicines, (2007)

exercise and inappropriate nutrition which combine to cause heart and circulatory problems, diabetes, respiratory disease and kidney disease. However as, in this population, these occur earlier and in a greater proportion there are specific compounding factors many of which relate to barriers which appear to inhibit adequate access and utilisation of the health facilities available.

Barriers

A number of barriers have been identified which impact on the health and well being, and therefore lead to an adverse life expectancy amongst Indigenous people. These barriers include actual access to medications, cultural differences and limited Indigenous health workers with whom the Indigenous community can relate. Some of these barriers result in poor adherence to medication regimens – a problem with which pharmacists are particularly conversant and one where we can offer effective assistance.

A View from the Front line[3]

"The adherence with medication in the Indigenous community is dreadful compared to the average. Poor adherence is very common and this can be due in part to poverty and lack of life management/ prioritisation skills. Indigenous clients fail to collect prescriptions for themselves or their relatives, including children, or sometimes they do not collect them for several weeks, or until pension day or 'bed money' (family allowance) day. We have learned, for example, NEVER to reconstitute antibiotic mixtures until the person collects the script because if we do, 50% of them go out of date in the fridge. The problem is compounded by 'entitlement issues' including doctors writing private scripts without regard to a person's ability to pay. 70% of the time an entitled Indigenous person WILL go without treatment rather than pay more than $4.90. We need education/ intervention at point of prescribing and in the pharmacy – or possibly a local formulary approach – to deal with such problems.[4]

*A somewhat separate issue is <u>*non-compliance with long-term medication, especially by aged personnel*</u>. We pack quite a few Dose Administration Aids (DAAs) for elderly patients and about 50% of these are >10% non-compliant (and sometimes >70% non-compliant) with regimen despite the DAA. I believe this is because these patients cannot cope with a DAA unaided and are – by definition – not receiving the level of family/ community health/ home care intervention they require, or at least the help they are getting is clearly not impacting on their medication management. Our pharmacy could help from here with adequate resources – for example with a pharmacy-trained AHW who could get around and see people and/or work with the Aboriginal Health Service and NSW Home Care to address specific problems with specific patients. But that is currently a pipe-dream."*

[3] Comment to writer by PSA pharmacist member practising in a remote community pharmacy during development of this submission.

[4] For example: Rather than use mupirocin cream @ $19 per tube, substitute a simple inexpensive effective antistaphylococcal compound antibacterial like Medicreme ($7)

A Role for Pharmacists – An Overview

The Society believes the role of the pharmacist in improving and maintaining positive health outcomes in the community, be it metropolitan, regional, rural or remote areas of Australia is under utilised. Accordingly, we submit the following suggestions on how the Society and its members might assist in overcoming some of the issues and barriers to work with the NSW community to improve the health and therefore the longevity of its Indigenous members.

Context

In preparing this submission the Society was cognisant of the following programs and initiatives already in place:

a) The 4th Community Pharmacy Agreement – considerable funding is being allocated to support a research project with the aim to deliver and evaluate a program that improves PBS accessibility for Aboriginal and Torres Strait Islander peoples by supporting the implementation of quality use of medicines (QUM) work plans in each Aboriginal Community Controlled Health Service (ACCHS) and the community pharmacy network in rural and urban Australia. Part of the funding will be earmarked to enable each ACCHS to directly access medications which may not be currently be available to them through the S100 program.

   Also as part of this project the Pharmaceutical Society of Australia at a national level will be involved in producing and delivering medicines orientated training program for Aboriginal Health Workers (AHWs), as well a Cultural Awareness Training program for pharmacists. Further, the National Prescribing Service (NPS) has produced a Quality Use of Medicines education program for AHWs.

b) Funding is now available to support scholarships for Indigenous people seeking to study pharmacy.

c) The NSW Department of Health through its HealthOne initiative is seeking to deliver care in a way that is different from conventional community health or GP services whilst also reducing duplication of, and improving, services for patients and their families. This clinical redesign process is challenging, especially where there are public and private partners involved. It requires re-orientating primary health care to incorporate strong health promotion, illness prevention and early intervention foci.

Opportunities

Bearing the above in mind, the Society has identified a number of opportunities for the pharmacy profession to become more closely and integrally involved in improving health outcomes for the Indigenous community. Specifically, it is proposed that the Society:

1. enter into partnerships with NSW Department of Health through its HealthOne and other initiatives so that pharmacy expertise and resources can effectively support health promotion, illness prevention and early intervention strategies;

2. provide education, counselling and mentoring support to AHWs and pharmacy students from Indigenous backgrounds.;

3. work with all other members of the Indigenous Health Care team to improve opportunities for immediate access to prescribed medications;

4. work with all other members of the Indigenous Health Care team to improve adherence to medication regimens and to reduce confusion over medication; and

5. provide medication reviews to all Indigenous persons being treated for chronic conditions, whether they are patients in acute care or long term care facilities or are ambulatory[5].

There is strong support for increasing the role of pharmacists, and specifically trained and supported AHWs within a multidisciplinary team approach to QUM. It suggested this could include consideration of enhanced outreach pharmacist services and improved coverage of Home Medicines Reviews, the creation of primary care QUM facilitator positions to support QUM systems development, auditing, feedback and patient and staff education.[6]

Several of those interviewed during the compilation of this report also mentioned the possibility of training health workers or other community members to be employed and supported as pharmacy technicians within primary care services.

It also noted that a range of information and patient education needs were identified through the consultation phase of the evaluation, including support for advice and training in all areas of medication management for health service staff and the provision of up to-date, easy-to-read, plain English medicine information for client and staff education. This information must be culturally appropriate as information is essential if Indigenous clients are to make informed choices relating to appropriate therapies and adherence to medication. For example one of our members stated that *"We have to discuss their antihypertensives as what would happen to their ability to look after their women and children if they did not take it."*

The Pharmacist's Role – Health Promotion, Illness Prevention and Early Intervention Strategies

To maximise the contribution pharmacy can make in these areas, the Society proposes that components of its highly successful Pharmacy Self Care (PSC) program be reproduced in a culturally appropriate form for use by Indigenous Australians. Further, it is proposed that each ACCHS in NSW (whether urban or rural) become a participant in the Pharmacy Self Care program in partnership with a PSC pharmacy member. PSC pharmacist members could then mentor, educate, work with and support (as needed) the AHW to maximise the health promotion and illness prevention opportunities offered by PSC.

[5] Objectives of such reviews would include considering regimens that best fit with patients' lifestyle as well as ease of access to medications.
[6] Brown, A (2007), Ensuring the Quality Use of Medicines, (2007)

Pharmacy Self Care

Pharmacy Self Care is the leading health information and education program in Australian pharmacy. Twenty-five years ago, when the Society began this program to assist community pharmacy, the NSW Government generously provided seed funding for its establishment. Over the intervening period this program has been adapted to meet the changing needs of the general community and it has been acknowledged world wide as a simple and effective process for the dissemination of scientifically sound health related information backed by the expertise of pharmacists.

Within a few weeks of the launch of this program, the Society received anecdotal reports of people, who having accessed some of the information it provides, realised they had symptoms which indicated the existence of type II Diabetes and as a result consulted their GP with the diagnosis confirmed. Unfortunately while there are no statistics or research data to quantify how many such instances have occurred in the past quarter of a century, anecdotal reports, and small research projects continue to indicate the effectiveness of this strategy.

The lynch pin of the program is a range of consumer friendly, easy to read, appropriately reviewed Fact Cards which target all the identified key health areas which affect the Indigenous population – Circulatory and Heart disease, Respiratory Disease, Kidney Disease, Alcohol and Tobacco, Nutrition and Exercise[7].

The cards are written to a reading age of 12 years and the editorial content does not contain any subjective promotion and/or endorsement of any pharmaceutical or complimentary health product. A card's content is based on accepted clinical guidelines relating to the topic and each card is reviewed and updated every 12 months in reference to the latest research and clinical guidelines. They are designed primarily as counselling tools that can be tailored to individual needs.

The Fact Cards are supported by a range of materials to:

- maintain the currency of knowledge of the areas of health care covered by the cards;
- up-skill and support the competency of support staff; and
- provide additional information to consumers on general health care matters.

The Fact Cards and supporting material lend themselves to culturally appropriate adaptation. This has been done previously when a small range of fact cards were rewritten for recently arrived Vietnamese refugees. Adapted cards could be used by pharmacists and AHWs as an educational and counselling tool to begin to enhance understanding of disease processes and the role of medication and life style changes in improving the quality and quantity of life of the Indigenous community.

[7] There are approximately 80 titles in circulation. The complete list appears in the appendix.

Recommendation 1

That the Society work with a small team of Indigenous health workers to adapt a quantum of Pharmacy Self Care Fact Cards to meet the needs of the Indigenous community.

That each ACCHS in NSW (approx 50) become a participant in Pharmacy Self Care (PSC) in partnership with a Pharmacy Self Care pharmacy member and access sufficient of the fact cards and adapted fact cards to meet the needs of their local community. This opportunity could also be offered to each HealthOne facility especially if they have included pharmacy in their comprehensive health care team.

That the Society devise an education program based on the PSC material which can be completed by each AHW with the support, if required of a PSC program pharmacist. The course will be designed so that on completion the AHWs will be fully equipped to effectively use, adapt and explain the information contained in the Fact Cards for the benefit of the communities they serve. A PSC liaison officer who can regularly visit each ACCHS and AHW and provide ongoing support and advice would be an essential part of this initiative.

Early Interventions

As previously mentioned, reducing the incidence of Rheumatic Heart Disease (RHD) in the Indigenous community will assist in reducing the burden of cardio vascular and renal diseases. One of the leading causes of RHD is rheumatic fever resulting from streptococcal infections. This is now very uncommon in the non-Indigenous community due to the early use of simple antibiotics in children. As outlined above there can be very poor compliance when antibiotics are prescribed for children. If the prescriber and/or the AHW had available ready "dispensed" antibiotic chewable tablets, tablets or simple penicillin mixtures which could be provided to the patient immediately on diagnosis, and these were provided along with necessary counselling and other support material to explain why it is essential the course be commenced immediately and the prescribed course completed there is a chance the incidence of RHD could begin to be reduced.

Cigarette smoking is another factor which is a major contributor to the increased disease burden of the Indigenous community. There are now available a wide range of nicotine replacement products available through pharmacies to help reduce nicotine addiction arising from cigarette smoking. Pharmacists have played an important role in assisting to reduce the overall rate for smoking in the general community.

There is therefore an opportunity for the Society to work with smoking cessation experts and AHWs to devise strategies, acceptable to members of the Indigenous community, which will assist to wean smokers from the Indigenous community from this habit.

Obviously some of the most important interventions to prevent or reduce the burden of disease are life style changes and adherence to medication regimens once initial symptoms of disease are diagnosed. Pharmacy has much to offer to assist in adherence to medication regimens and as already mentioned our expertise can assist in promoting attributes of a healthier lifestyle

Formulary

As previously mentioned, it is understood that there is a national program being developed to provide funding and other support to assist the ACCHS gain better access to Pharmaceutical Benefits Scheme (PBS) medications. This would not prevent the development of a medication and possibly medical devices formulary being developed. If there was a template formulary then each ACCHS could adapt this to meet the specific needs of their community, and use of such a formulary would not prevent items outside the list being accessed for particular situations.

Important criteria in determining what to include in such a list would target Australia's National Quality Use of Medicines Policy and would encompass the simplicity of dosing (as adherence to medication regimens decreases with the number of doses to be consumed each day) and the cost benefits of each preparation. The continuing availability of only one brand of each medication would assist in reducing confusion in both patients and carers as well as possibly reducing needless waste.

An imprest system for prescriptions and dispensed medicines, with new packs being provided when a prescription is received for a pack that has been supplied, could control the supply and enable the pharmacist and the AHW to monitor the medication and follow up adherence.

Similarly it has been postulated that if persons with hypertension within the Indigenous community regularly took an ACE inhibitor this would markedly decrease the incidence of renal disease. Inclusion of one ACE inhibitor preparation, with a half life so that it need only be taken once or twice a day would be another essential item on the formulary.

While the PBS is itself a formulary, a more restrictive list which targets the specific needs of its clientele is normal for Australian public hospitals and it is also a device used by some countries to maximise the cost effectiveness of its limited health care expenditure.

Recommendation 2

That the Society work with a committee representative of AHWs, prescribers to the Indigenous community and medical specialist in Cardiovascular, Respiratory and renal medicine to determine a template formulary for ACCHS. The template formulary should include the rationale for the inclusion of each item

Following completion of this template and associated rationale, the AHW members of the committee could, meet with representatives of each ACCHS in NSW to outline the formulary and encourage them to adapt it to their specific needs. A pharmacist from their PSC partner pharmacy could be involved in these discussions.

Recommendation 3

That the Society work with smoking cessation experts and AHWs to devise strategies acceptable to members of the Indigenous community which will assist to wean smokers from the Indigenous community from this habit.

These strategies then be promoted to all AHWs and PSC pharmacy partner members and incentives devised to encourage their adoption throughout the Indigenous community.

Adherence

Providing medication in an appropriate, easy to use dose administration aid (DAA) has been proven to improve adherence. The number of programs in which these devices have been provided to members of the Indigenous community have identified a number of additional factors which must be considered especially for those persons who maintain an itinerant lifestyle. The pack must have some child resistant properties as to assist in reminding patients to take their medication it must be placed in clear sight of the patient. The simple "Dosette" box has proven unsuitable while a program in the Tiwi Islands has identified that an easily transportable "clamshell pack" which is a semi-durable blister pack has improved both adherence to medication and improved continuity of supply[8]. Similarly, there exists a web-based program which, with the permission of the patient, could allow pharmacies and ACCHS, regardless of location, to access the patient's medication profile and ascertain when medication was supplied, and when continuing supplies are due.[9]

Notwithstanding these mechanisms, there is still the need for a human element to provide reassurance that while symptoms may not be currently discernable, medication for chronic conditions should continue to be taken. There is also a need to ensure there is continuation of supply. A pharmacy trained AHW who can visit these patients provide the counselling and reassurance to ensure continuation of medication consumption and who can make sure there is continuation of supply would be a most useful resource to improve adherence.

Recommendation 4

That criteria be established for the issuing of "clamshell pack" DAAs and that funding be made available to provide "clamshell packs" to those members of the Indigenous community meeting this criteria and for pharmacists to prepare these DAAs. This criteria and this funding to be reviewed when the devices with visual and audio reminders becomes available.

That information about these devices be provided to AHWs, ACCHS and HealthOne facilities and the Pharmacy Self Care program pharmacists work with the AHWs and the facilities to integrate the use of these devices.

[8] This device has been designed by Webstercare, a wholly owned Australian company, who are currently developing a device which will flash and beep each time a dose is due to be consumed.
[9] See http://www.webstercare.com.au

Medication Reviews

More than 10 years ago the National Health Service acknowledged the positive benefits that accrue when appropriately trained pharmacists regularly review a patient's total medication profile together with their physiological data (blood sugar, kidney function etc) and segments of their lifestyle which could effect medication and disease processes. Initially pharmacists were paid to provide this service to people in long term care facilities and for the past 6 years this payment has been extended to persons residing at home who met some simple criteria.

The Brown Report for the Heart Foundation Report, cited previously) and other reports have indicated that such reviews would be most useful for Indigenous persons also, and while a number of pharmacists have tried to provide such a service they have encountered a number of barriers.

Ms Fran Vaughan, a pharmacist working in the Northern Territory has documented a number of these. In particular it has been found that having a pharmacist who is not known to the community and is not familiar with the community is not accepted. Patients often do not keep their appointments for many, often, cultural reasons. In providing input into this submission, Ms Vaughan related how, having arrived at a particular settlement, she could not complete scheduled medication reviews due to urgent tribal business. Rather than returning to her pharmacy, she remained and spent some useful time with a group of Indigenous people talking about medications and disease processes. This is despite the absence of any support, in particular financially, for such activities.

Clearly, as noted by one of our rural members, the situation puts quite a bit of care responsibility back on the pharmacy. Pharmacists could accept this responsibility and in many ways are best placed to do so, provided they are given the resources they need to do so. For the most part the resources required means additional residential manpower, both pharmacist and AHW. Models of service based around of visiting providers, including for example accredited pharmacists, are not considered optimal as they do not have an ongoing level of contact which allows them to become known to the community.

> ***A View from the Front Line***[10]
>
> *HMRs for members of the Indigenous community have a important role to play in improving adherence and medication management. The fundamental challenge is to manage to complete a medication review. There is already too much work here for one pharmacist. Therefore I'm forced to rely on accredited pharmacists prepared to visit for 2 days at a time to do them, and that approach simply does not 'engage' local prescribers and generate the necessary referrals. I need an accredited pharmacist working with me here, 'on the ground', to create the necessary momentum, exactly as it would happen anywhere else. Why do people think that a second-hand, second-rate approach is 'good enough' for remote areas? It wouldn't work in the city, and it won't work here. I could get an accredited pharmacist here on the ground, but only through an innovative approach to pooling Commonwealth, State and private (ie: my own) money to fund a full-time residential position to meet*

[10] Comment to writer by a rural PSA pharmacist member during development of this submission.

this and various other resource needs. Communities like mine must have 'community-owned' resources (i.e. people who live here and deal 'ongoingly' with the myriad of social and health issues at root cause, as opposed to occasional well-intentioned visitors who aren't engaged for long-enough to make a difference. It is absolutely fundamental.

By choosing to practice at the Indigenous coalface so to speak, in a remote country town, I have already 'bought into' these problems; they are 'mine' to live with every day. I do need help though. Help me engage the resources I need to provide practical solutions, and I will provide them. Try to have the problems addressed from outside and leave me on the margin, and, you'll have marginalised me!

Recommendation 5

That a trial be undertaken whereby a small number of pharmacist positions (say 3 in remote areas, 2 in rural, and 1 in an urban area) be funded with the specific objective to determine the effectiveness of personnel continuity in undertaking Medication Reviews and the resulting benefits from these. These positions should also include liaison with AHWs and counselling and education of patients and their carers.

Disease State Management

Over the past several years rigorous university based research projects have identified and evaluated protocols which support the effective role for pharmacists in Disease State Management. Funding has been included in the 4th Community Pharmacy Agreement for Disease State Management program in Diabetes. Similarly, funds have been identified for an Asthma program. Both of these programs are based on research undertaken and initiatives developed by The University of Sydney Faculty of Pharmacy.

It should also be noted that Charles Sturt University has examined how pharmacists can assist patients suffering from depression.

There is potential therefore for these types of programs to be introduced into a pharmacist's health care offerings to the Indigenous community and the Society would welcome the opportunity to explore this further with the relevant NSW Government departments and Indigenous organisations.

Conclusion

There are many barriers which are preventing members of the Indigenous community effectively accessing and utilising many of this state's health care resources. To the majority of our community, pharmacists are the most accessible of all health care professionals even though, in the main they are not part of the public health care sector. In this submission we have identified proposals which we believe the pharmacy profession, through leadership of the Society, can make a major contribution to improving the health and wellbeing of Indigenous Australians, thereby the reducing the Indigenous adverse life expectancy gap.

The Society looks forward to the opportunity to discuss these proposals further with the Committee and, in future move forward in partnership with the Government, Indigenous community and other health care providers to address the current shameful situation.

SUMMARY OF RECOMMENDATIONS

Recommendation 1

That the Society work with a small team of Indigenous health workers to adapt a quantum of Pharmacy Self Care Fact Cards to meet the needs of the Indigenous community.

That each ACCHS in NSW (approx 50) become a participant in Pharmacy Self Care (PSC) in partnership with a Pharmacy Self Care pharmacy member and access sufficient of the fact cards and adapted fact cards to meet the needs of their local community. This opportunity could also be offered to each HealthOne facility especially if they have included pharmacy in their comprehensive health care team.

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Recommendation 3

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These strategies then be promoted to all AHWs and PSC pharmacy partner members and incentives devised to encourage their adoption throughout the Indigenous community.

Recommendation 4

That criteria be established for the issuing of "clamshell pack" DAAs and that funding be made available to provide "clamshell packs" to those members of the Indigenous community meeting this criteria and for pharmacists to prepare these DAAs. This criteria and this funding to be reviewed when the devices with visual and audio reminders becomes available.

That information about these devices be provided to AHWs, ACCHS and HealthOne facilities and the Pharmacy Self Care program pharmacists work with the AHWs and the facilities to integrate the use of these devices.

Recommendation 5

That a trial be undertaken whereby a small number of pharmacist positions (say 3 in remote areas, 2 in rural, and 1 in an urban area) be funded with the specific objective to determine the effectiveness of personnel continuity in undertaking Medication Reviews and the resulting benefits from these. These positions should also include liaison with AHWs and counselling and education of patients and their carers.

APPENDIX 2

SELF CARE FACT CARDS

CHILD HEALTH
Child Immunisation
Infant Colic
Nappy Rash

CHRONIC CONDITIONS
Alzheimer's Disease
Rheumatoid Arthritis
Asthma
Asthma Medicines
Back Pain
Diabetes Type 1
Diabetes Type 2
Epilepsy
Gout
High Blood Pressure
Osteoarthritis
Osteoporosis

EAR,NOSE & THROAT
Colds & Flu
Coughs
Dry Mouth
Ear Problems
Hayfever
Sinus Problems

EXERCISE
Exercise & the Heart
Exercise for Flexibility
Pelvic Floor Exercises
Sprains and Strains

EYE CARE
Contact Lens Care
Red & Dry Eyes
Vision Impairment

GASTROINTESTINAL
Constipation
Haemorrhoids
Heartburn & Indigestion
Irritable Bowel Syndrome
Threadworms
Vomiting & Diarrhoea

GENERAL HEALTH
Chickenpox
Headache
Bladder & Urine Control
Meningococcal Disease
Migraine
Mouth Ulcers
Nicotine Replacement Therapy
Pain Relievers
Preventing Falls
Smoking
Staying a Non-Smoker
Thrush
Travel Health
Urinary Tract Infection

MENS HEALTH
Erectile Dysfunction
Men's Health
Prostate Problems

MENTAL HEALTH
Anxiety
Depression
Post-traumatic Stress Disorder
Relaxation Techniques
Sleeping Problems

NUTRITION
Fats & Cholesterol
Fibre & Bowel Health
Vitamins
Weight & Health

SELF HELP
Alcohol
Antibiotics
Complementary Medicines
Drug Overdose
First Aid in the Home
Generic Medicines
Help with Medicine Costs
Wise Use of Medicines

SEXUAL HEALTH
Genital Herpes
HIV/AIDS

SKIN CARE
Acne
Cold Sores
Dandruff
Eczema & Dermatitis
Hair Loss
Head Lice
Scabies
Sense in the Sun
Shingles
Tinea

WOMEN'S HEALTH
Menopause
Period Problems

Current as at: 30 January, 2008

APPENDIX 2

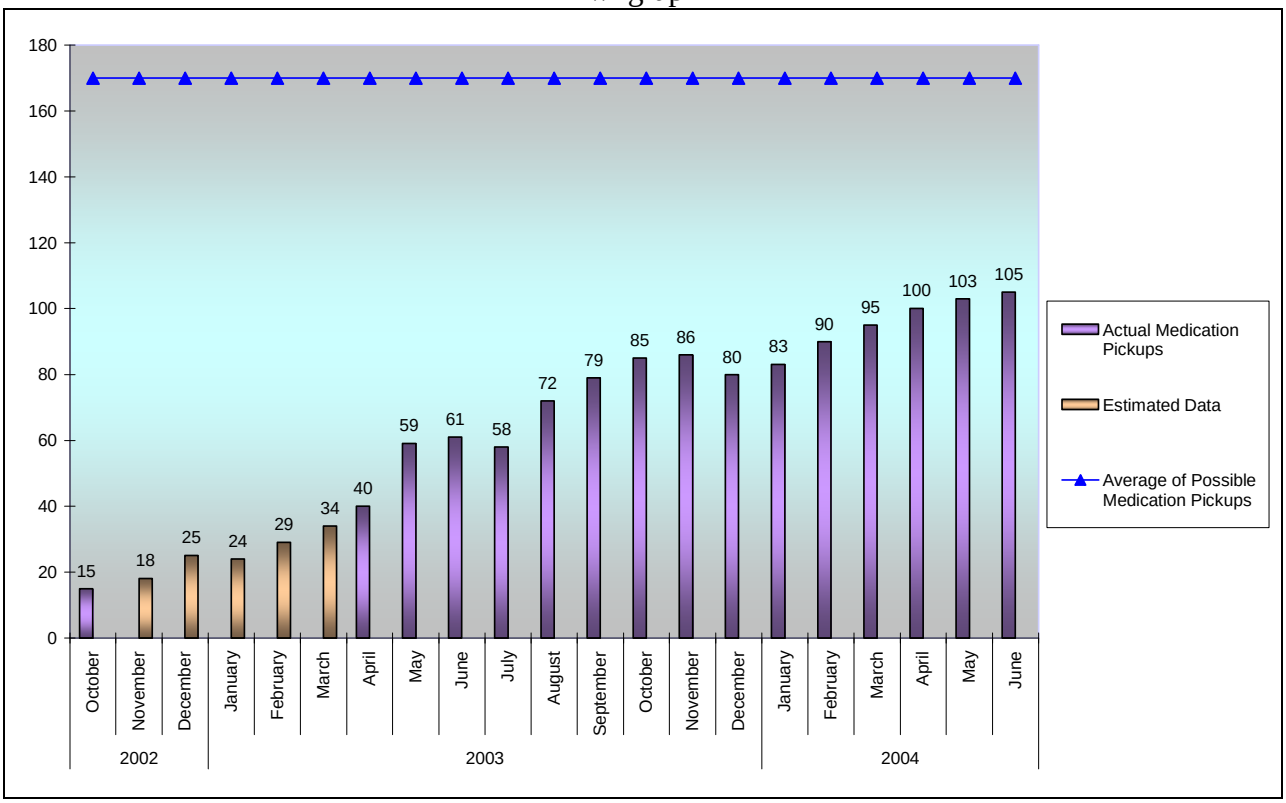
WEBSTERCARE COMMITMENT TO MEDICATION COMPLIANCE

Webstercare has been working on innovative DAA solutions to assist in medication compliance since 1980 and the Tiwi Islands Health Board in particular since 2000.

Any solution developed by Webstercare for remote and aboriginal communities has been to ensure that the patients / clients receive the right medication at the right time in the most user friendly way. Webstercare solutions are unique and tailored with input from the communities during the design process to ensure that the final product is right for them.

Using Webstercare Products there has been noticeable improvement in compliance.

Tiwi graph



Innovative Dose Administration Aids (DAA) Solutions

Webster-pak® Clamshell-pak ™

The Webster-pak Clamshell-pak was designed specifically to meet the needs of aboriginal communities. The Clamshell-pak is for people who wish to pack medication into a compartmentalised box/ dosette type container or for people to pack medication for themselves or for someone for whom they are caring.

Currently the Clamshell-pak is being introduced into the Kimberley's as a substitute to the use of dosette boxes. As dosette boxes are expensive to replace, the users are reluctant to change them over even when they are no longer able to be used e.g. broken, too dirty (impossible to clean). This has caused both hygiene and compliance issues. There are Issues also for staff in the pharmacy or AHW's who are reluctant to touch contaminated boxes.

The Clamshell-pak has been seen as an economical semi disposable replacement, as they are inexpensive enough to be replaced when they are no longer usable.

Webster-pak® Clamshell-pak ™ Holder

At requests of the Kimberley communities for a way to keep the Clamshell-pak dosage times together a Clamshell-pak Holder has been developed.

The Clamshell-pak Carrier can hold 2 dosage times as feedback received from the communities was that the most common dosage times were Breakfast and Dinner. The objective of keeping the number of dosage times to a minimum is to achieve better compliance.

See Photo (Right):

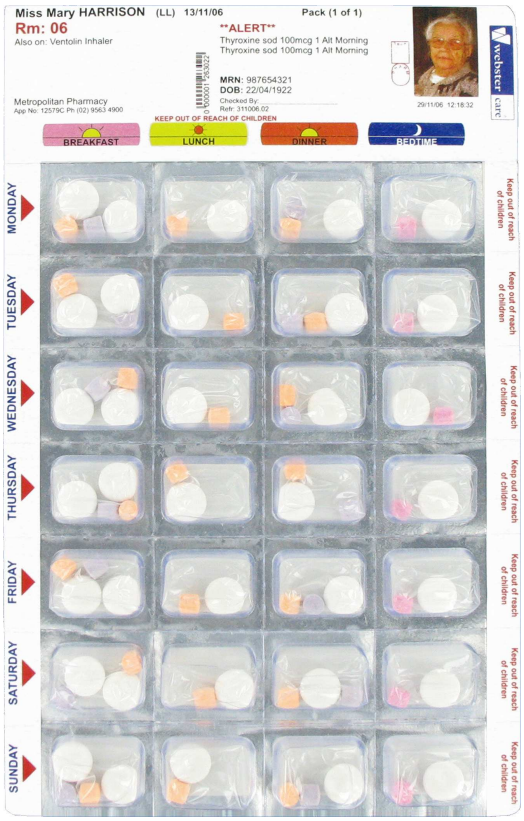
Cold Seal Flexi-pak ™ Webster-pak®

The Cold Seal Flexi-pak is unique. It has been developed to give portability to the client's medication. As not all clients keep their medication in their kitchen or by their bedside table, a solution was needed for a pack which could be easily rolled up and stored in a bag whilst ensuring the integrity of the medication and that all doses are protected for compliance.

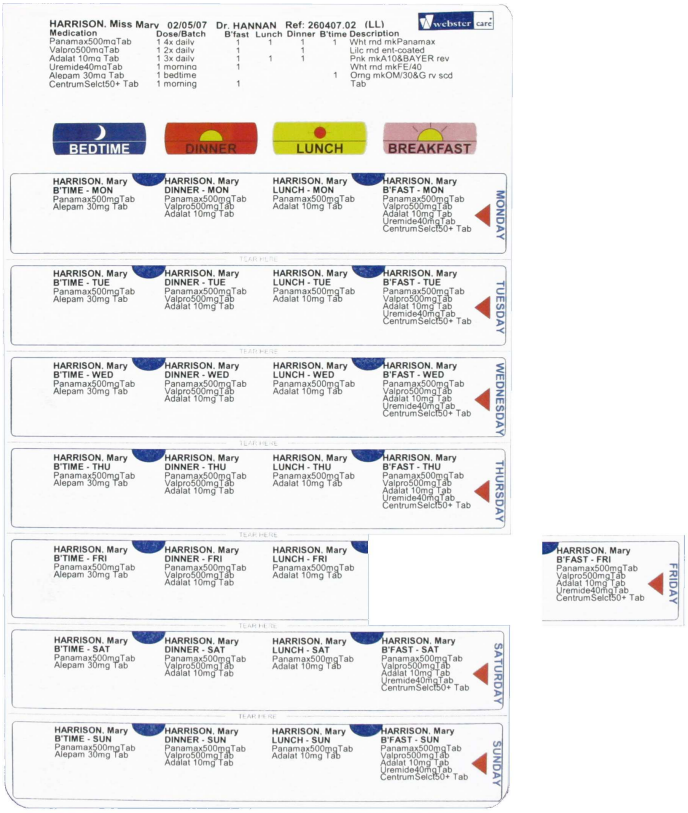
With this added portability unique design features have been incorporated into the design:

- A strong foil which will keep the integrity of the pack when rolled
- Unique micro-perforations (patented) to ensure that the removal of medication is easy with the stronger foil
- Perforated pack so the client can remove a dose they may need without having to take the whole pack with them
- Perforated pack which assists in the rolling of the pack
- Heat resistant adhesive to account for the very high temperatures in the remote communities
- A water resistant container which will protect the rolled up pack in a bag as well as keep any removed doses together

Webster-pak gives Aboriginal Health Workers, nurses, pharmacists and doctors control of medication and frees up time to care for their clients. Webster-pak ensures clients get the medication they need at the times they need it.



Front of Pack

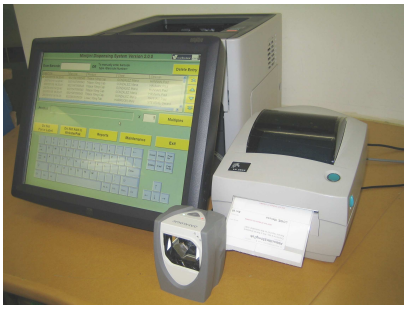


Back of Pack

Cold Seal Flexi-pak in Webstercare Carry Safe

Innovative Software Solutions to Compliance Monitoring

Mirrijini Dispense System



The Mirrijini Dispense System incorporates two major components:

- Recording Medication Supplied
- Stock Control System

Recording Medication Supplied

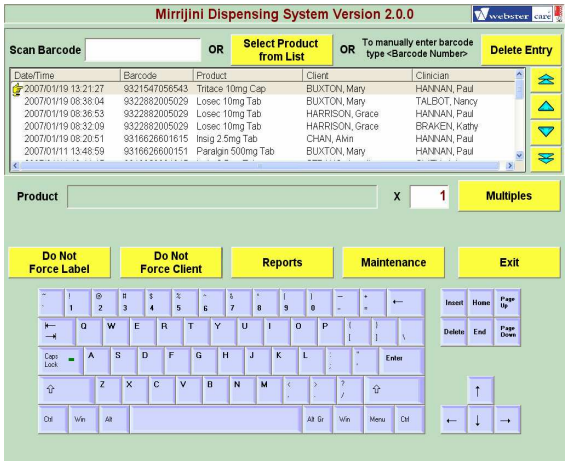
The Mirrijini Dispense System (MDS) is designed for use in the pharmacy room of an Aboriginal Health Service to assist in dispensing and inventory (stock) management. To save time and to simplify the dispense process MDS uses barcodes and a touch screen. As each medication prescribed has a unique manufacturer's barcode, this barcode is used to identify the medication name and strength to ensure that the correct medication is picked every time. Once this medication is scanned, a step by step process is followed to record the patient, clinician, doctor, and dosage. After the information has been entered a label can be printed to identify the patient, medication and dosage. This label is applied to the medication being supplied. This process takes less than 30 seconds to complete and records vital dispensing information.

MDS was developed as a means of recording:

- Name of the Drug Supplied
- Name of the Clinician making the supply
- Person to whom it was given
- Doctor who ordered the supply – where needed in accordance with local poisons regulations

MDS also prints:

- Label for applying to the supplied medicine (includes all required information)
- Total Medicines used in a given period Report
- Client Medication Profile Report
- Usage Report per Medication Report



Main MDS Screen

Dispense Data Entry

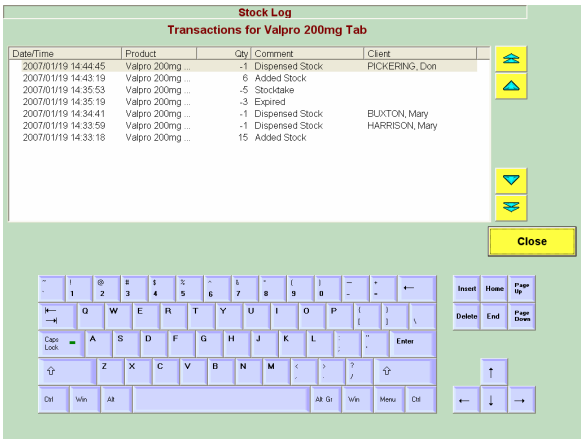
Stock Control System

The second component of the Mirrijini Dispense System is a stock control system. This stock control system provides a simple and efficient means of recording stock on hand. When orders are received the new stock is entered into MDS. This ensures all the medication stored in your pharmacy room is accounted for. Each time a medication is dispensed this stock total is reduced by the amount supplied, giving a snapshot of your stock levels at any one time.

<u>Stock Control Reports:</u>

By printing a report you can assess the current stock levels and compare this to the report of the total medicines used in a given period of time, to ensure optimal stock levels at all times. Other reports enable stock management via stocktake and the tracking of stock supplied.

Stock Control System



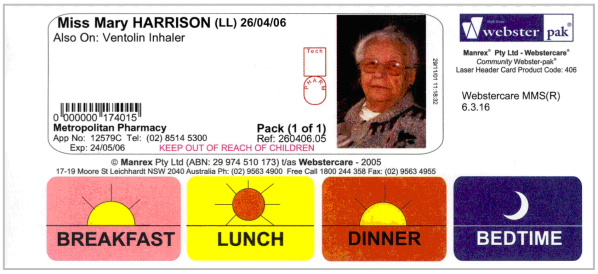
Stock Log per medication

Webstercare Medication Management Software

The Webstercare Medication Management Software (MMS) has been designed to monitor compliance from ensuring the pack has been collected at the right time to what medications have been returned – not taken.

BARCODE Identification

Scanning Packs on Pick-up



Every header card that is printed through MMS is allocated a unique barcode. The barcode uniquely identifies the patient, the pack, the medication in each of the 28 blisters, and start date of medication and the time and date of expected administration ro consumption. As each pack is collected from the Clinic / Pharmacy it is scanned and the time and date that the pack was collected is recoded.

The information obtained from the simple scanning step is it can identify when a pack is collected if it is later than expected, or identify packs not collected.

Scanning Packs on Return

When the packs are returned, if there are any doses remaining, the barcode on the pack is scanned and using a touch screen, the Clinic / Pharmacy worker records the doses that are remaining by simply touching the square on the screen that matches the pack.

As the barcode records the patient, their medication and start date, when the worker touches the blister remaining on the touch screen, the program automatically records the medications remaining, qty and any provision for alternate dosages as well as the dosage time (day and time) of the medication remaining.

From this, reports can be generated to determine if there are any trends in missed medication, e.g. every dose on Wednesday lunchtime. This information can be used to determine if the medication schedule needs to be changed to improve compliance and the effectiveness of the medication.

This is a software program unique in the world. From scanning to recording missed doses takes just **THREE** seconds.

Multi Lingual Webster-pak

This system has been introduced to assist non-English speaking patients with remarkable success. As people age and especially in dementia people revert to their mother tongue.

This is an opportunity for us to design special symbols and day of the week symbols, characters or words that may assist the Indigenous population. Our 'in-house' design and product development department can rapidly respond to this idea. Provided we have the artwork for the symbols or the words, we can design the appropriate labels and header cards so they print automatically from the Webstercare MMS software.

See example below of Multilingual Webster-pak.