

Australian Pharmacy Council

Remote Rural Pharmacists Project

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Glossary of Terms

Aboriginal Health Service (AHS)

A State/Territory or Community Controlled organisation which provides primary health care services to Aboriginal and/or Torres Strait Islander people.³⁶

Cognitive Pharmacy Services

Services provided by pharmacists utilising their knowledge and expertise to enhance drug therapy and disease management, through interaction with the patient and other health professionals where required.³⁷

Concordance

Concordance acknowledges the role of the patient in taking an active role in their health care and medication adherence.⁴⁵

Counselling

Counselling refers to medication counselling. Medication counselling is defined as the process of providing information, advice and assistance to help patients use their medications appropriately. Counselling can be verbal, written or visual methods of communication.³⁸

Dosage Administration Aids (DAAs)

Dose administration aids are devices that assist patients with their medication management by dividing their medicines according to the dose schedule as prescribed by the patient's doctor.³⁹ e.g. dosette boxes, Webster packs.

Dispensing

Dispensing refers to a pharmacist receiving a prescription, assessing it against consumer needs and safety, and accurately labelling and supplying the medicine.⁴⁰

HMR

A Home Medicines Review (HMR) involves a GP consultation to generate the referral, a pharmacist interview with the patient (preferably in the patient's home), a clinical assessment by the pharmacist and a written report back to the GP.

MBS

The Medicare Benefits Schedule is a listing of the Medicare services subsidised by the Australian government. This scheme managed by the Department of Health and Ageing and administered by Medicare Australia.

Outstation

An outstation (also known as an outreach clinic) is a remote permanent health service of a primary AHS that participates in s100 supply arrangements.

Pharmaceutical Benefits Schedule (PBS)

A list of medicines and the conditions for which they can be prescribed. These medicines are subsidised by the Commonwealth Government.

Pharmaceutical Care

A philosophy of practice in pharmacy in which patient's health outcomes are the key concerns and which involves the identification, resolution and prevention of drug related problems.³⁷

Pharmacy

The business of supplying pharmaceutical benefits, at or from, the particular premises in respect of which a pharmacist is approved under section 90 of the Act.³⁶

Pharmacist

A person registered as a pharmacist or pharmaceutical chemist under a law of a state or territory providing for the registration of pharmacists.³⁶

Pharmacy Services

Pharmacy services are the supply, compounding or dispensing of medicines; and advice and counselling on the effective and safe use of medicines.⁴¹

QUM

Quality Use of Medicines

Remote

Remote refer to locations that are geographically, professionally and personally isolating with limited access to medical support and peers.⁴² (Pharmacy ARIA Categories 5&6).

RMMR

Medication Management Reviews conducted in Residential Aged Care Facilities are called Residential Medication Management Reviews (RMMR).

Rural

Rural refer to locations with some restricted access to goods, services and social interaction. (Pharmacy ARIA Categories 2-4).⁴³

Section 100 (s100) Supply

The bulk delivery of PBS medicines, without dispensing and labelling, to a remote AHS, free of charge, according to Section 100 of the National Health Act (1953).³⁶

Telepharmacy

Telepharmacy is when a pharmacist uses information technology to remotely supervise the dispensing process and medication counselling of patients.

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1 Executive Summary

The Australian Pharmacy Council is aware of difficulties confronting pharmacists who are working in remote rural regions. An Expert Reference Group consisting of people with experience in remote pharmacy practice and one with a legal background was established to oversee a Project that would make recommendations to Government regarding legal impediments to remote pharmacists in delivering their full range of services.

A project consultant was employed to examine and report on barriers experienced by remote pharmacists that impeded their delivery of pharmacy services. The consultant conducted a literature review and conducted semi-structured interviews with twenty eight rural and remote pharmacists. Seven interviews were face to face. The rest were conducted by telephone. The consultant spent one week of experiential learning in the Central Desert, Western Australia, 1000kms west of Alice Springs.

The consultant found that remote pharmacists experienced a myriad of confusing state and national legislation. Current legislation “ties the pharmacist to the dispensary bench” in supply and dispensing functions. Legislation inhibits pharmacists, the medication experts, from dispensing outside a registered pharmacy and from delivering ongoing continuity of care through the prescribing of chronic disease medications. The states each have numerous pieces of legislation including a Poisons Act and a Pharmacy Practice Act. (see Appendix 3.5) The Commonwealth Government regulates the National Health Act, Medicare, Pharmaceutical Benefits Scheme and Section 100 medications. Not only is there confusion for pharmacists about legalities of medication supply but also regarding delivery of professional and cognitive services across state borders and within remote communities where distance and scarcity of health workers is an obstacle to optimal patient care. Pharmacists have proven expertise in delivery of clinical services. Reimbursement models for pharmacist clinical services need to be examined particularly in remote settings.

The introduction of the special supply arrangements under Section 100 of the National Health Act 1953 for the supply PBS medicines to remote Aboriginal Health Services has increased many pharmacists’ concerns about equity of quality of professional service provision in remote communities. Bulk medications are delivered to Aboriginal Health Services, and their outstations, where they are administered by nurses and Aboriginal Health Workers, who are not trained or supported in the process of dispensing or patient education on medication issues. Although the introduction of Section 100 has improved access of Aboriginal and Torres Strait Islander patients to medication it has in some areas also produced a “sub-standard” level of medication dispensing, labelling, advice and quality use of medicines for Aboriginal and Torres Strait Islander patients. It

has provided a second class service for these already disadvantaged Australians.

Poor quality use of medicines and low medication concordance levels in Aboriginal and Torres Strait Islander communities directly relate to high mortality and morbidity levels that would be unacceptable in urban communities.⁹

Current ownership and remuneration models for pharmacists inhibit the number of pharmacists in remote areas. In many areas it would be un-economical to open a pharmacy but an adequate remuneration model direct to pharmacists would make provision of pharmacy services viable. To increase clinical pharmacy services in remote areas it needs to become economically viable for a remote Aboriginal Health Service to employ a pharmacist. This could be achieved if pharmacy ownership models in remote areas were changed and/or if pharmacists could claim direct payment for clinical services (e.g. Medicare remuneration for service provision).

Lack of technological resources and legal impediments to their use mean that modern innovations such as video dispensing supervision and teleconferencing of patient case conferences are rare. Information technology is used effectively overseas and by other Australian health professionals, e.g. medical practitioners. Similar models could be implemented in remote Australia to deliver more effective patient care whilst addressing the issues of rural health workforce shortages and the tyrannies of distance. The introduction of electronic prescription transfer or “electronic prescribing” is imminent. Electronic prescribing should assist communication between prescriber and dispenser in remote areas and should improve patient profiling and record keeping and lead to better health outcomes.

The recommendations arising from this project include:

- Registering remote health clinics as pharmacy outstations, so that pharmacists may dispense in these locations.
- Remunerating remote pharmacists for cognitive services through the MBS.
- Authorising remote pharmacists to conduct prescribing by protocol.
- Allowing restricted operations, by protocol, in remote pharmacies without immediate supervision by a pharmacist.
- Embracing technology to allow telepharmacy and e-prescribing.
- Exempting Aboriginal Health Services in remote areas from pharmacy ownership laws, if a pharmacist is employed full-time to oversee and establish QUM observance.
- Supporting and subsidising electronic prescribing and internet based communications between health professionals.
- Aligning, simplifying and revising state health legislation.

Input from a pharmacist at the point of patient care has been shown to improve health outcomes and reduce health costs.^{21,22,38} A number of innovative models of practice are being trialled in other countries but adequate pharmaceutical care is not being delivered in remote Australia as a result of a number of structural, economic, logistical, workforce and legal impediments to remote pharmacy practice.

All Australians, not only those in urban areas, should have Quality Use of Medicines. Australian Government policy on QUM states: “to achieve quality use of medicines, people must be provided with the most appropriate treatment and have the knowledge and skills to use medicines to their best effect”.³³ Remote pharmacists can play a vital role in ensuring remote Australians have the knowledge and skills to appropriately use their medicines if innovative models of practice are implemented, legal impediments removed and recognition is given to the uniqueness of remote health care provision.

2 Recommendations

Recommendation 1

Remote health clinics/outposts be classified as a “registered outstations” for pharmacy services.

At these remote pharmacy outstations, pharmacists would be able to carry out the business of dispensing, labelling of medications, packing of Dosage Administration Aids, medication counseling and other cognitive pharmacy services.

The remote outstations for pharmacy services would be located at least 100kms from the nearest registered pharmacy, and meet standards set by the Pharmacy Boards. Licensing of these stations would not be transferable to any urban environment and primarily are to address the health needs of the areas in which they are situated.

Rationale:

- Pharmacists in most states are legally prevented from dispensing or packing Dosage Administration Aids outside a registered pharmacy.
- Currently, at many remote health clinics or health outposts dispensing or the packing Dosage Administration Aids can only be done by nurses or Aboriginal Health Workers. Often nurses and Aboriginal Health Workers are not adequately trained to dispense and label medications or to conduct medication counselling. Career pharmacists, with expertise in remote health but who do not want to own a pharmacy, should be able to be employed/paid to undertake this professional role for which they are best trained.

- Dispensing by pharmacists is permitted at remote Aboriginal and Torres Strait Islander clinics in the Northern Territory under a Health Minister approved exemption of Section 94 Health Act regulations. This recommendation suggests that, other states could create an exemption to their legislation for remote outposts, similar to NT legislation.
- Pharmacists, as medicine experts, are seen as the most appropriate health professionals to manage medication compliance and monitoring programs to improve the outcomes for their patients.¹⁸
- The implementation of Section 100 medications for remote area Aboriginal Health Services represents a breakthrough in medicines access but the transfer of dispensing and patient counselling functions from pharmacies to Aboriginal Health Services (AHSs) has raised issues of ensuring Quality Use of Medicines (QUM) and appropriate pharmaceutical support.⁶
- Cold chain, temperature control and security are important to ensure appropriate medication storage standards. Other outstations requirements should not be overly prescriptive or they will be unable to be implemented in remote areas.

Recommendation 2

Remote Pharmacists should be remunerated for clinical services through MBS item numbers.

Remote Pharmacists should be able to claim for a range of clinical services for which they are trained, including but not limited to, medication reviews, medication management, education and chronic disease management.

Some examples of remunerated clinical services include: medication counseling, immunisation, prescribing, wound management, blood pressure monitoring, blood glucose monitoring, asthma plans, patient case conferences with Medical Practitioners, (face to face or by phone), Home Medicines Review (already existing), Nurse and Aboriginal Health Worker medication education, medication chart reviews (nursing homes & outreach hospitals) and a range of chronic disease management services.

Rationale:

- The poor health status of Aboriginal and Torres Strait Islander people, documented low levels of medication concordance and cross cultural communication issues, indicate that considerable time is needed by pharmacists to explain medications and health issues. To enable pharmacists to invest time in counseling there needs to be some form of remuneration for their professional clinical services as there is for doctors, nurses and other allied health professionals.
- Medicines if used appropriately are cost effective. They improve health outcomes and quality of life and avoid costs caused by further medical

treatments and hospitalisations. Adequate knowledge of medications has been shown to decrease repeat presentations to doctors and hospitals and reduce antibiotic resistance.¹⁹

- A number of studies demonstrate a positive effect on diabetes and/or hypertension outcomes by involving a pharmacist in the primary health care team.^{21, 22}
- Poor Quality Use of Medicines in Indigenous communities directly precedes poorer control of chronic disease states and subsequent higher hospital admissions, morbidity and mortality.⁹
- Whilst there is an emerging crisis in rural and remote area nursing, exemplified by nursing shortages and the ageing of the nursing workforce, there has been a doubling of pharmacy graduate supply in the last 10 years.^{11, 23} If there was remuneration for clinical services, clinical pharmacists and pharmacy graduates may be attracted to working in remote rural regions. These highly qualified graduates could provide a mobile and focused health workforce in an area of high health need removed from the traditional role fixed within a pharmacy.
- Pharmacy students are developing a greater range of clinical skills and expertise and are looking for settings in which to utilise these skills.³⁸

Recommendation 3

Remote, credentialed, pharmacists should be given the authority to prescribe ongoing chronic disease medications according to a set of prescribing protocols.

Rationale:

- Pharmacists have extensive training in pharmacology, therapeutics, disease state management and therapeutic communications. The extension of prescribing rights to pharmacists has the potential to optimise medication management, improve continuity of patient care and improve patient access to medication.²⁸
- Limited prescribing rights have been given to other health professionals such as nurse practitioners, optometrist, dentists and podiatrists in Australia to address access and service needs.
- To enable service delivery at the point of care, together with other members of the healthcare team, the pharmacists should be able to practice in locations outside of a traditional pharmacy.
- A number of countries, including the UK & USA, now have effective health care models with prescribing pharmacists.

- GPs are overstretched, especially in rural and remote areas, and patients with chronic conditions often are not able to access an ongoing treatment plan.¹⁸ In some remote areas there are no GPs.
- Prescribing medications is not a simple process and requires more than knowledge of a drug indication. Knowledge of adverse effects, doses, optimal routes, drug-drug and drug-food interactions, pharmacokinetics and monitoring of effects is needed, and application of this knowledge requires significant expertise – expertise that pharmacists possess.³⁵
- Prescribing by protocol (non-medical) is the most common form of dependent prescribing. The protocol lists:³⁵
 - types of diseases, drug categories and prescriptive decisions
 - the procedure the pharmacist must follow when prescribing
 - the responsibilities of parties (pharmacist & physician) involved
 - length of treatment
 - criteria for referrals
 - the documentation required
 - the feedback mechanisms required
 - policies for review of protocols
 - pharmacist credentialing requirements
- Currently the prescribing and medication supply roles are often undertaken by a remote medical practitioner and a health worker of limited training. This needs to be addressed to ensure safety and quality of care delivery.
- In remote areas there are not always numerous health professionals available. In some rural areas doctors have a license to dispense, to ensure an adequate service to the community. Similarly, allowing a pharmacist to prescribe would assist a community where a doctor is not available.

Recommendation 4

Legislation needs to be in place to allow sole pharmacists in remote rural locations to provide pharmacy services to outstations and other areas outside the registered pharmacy without the need to close the registered pharmacy in their absence.

Rationale:

- Currently the pharmacy must close if there is no pharmacist present.

- In many rural and remote areas there is a shortage of pharmacists. In remote areas there is often only one pharmacist. This sole pharmacist may be both the community pharmacist and hospital pharmacist. The pharmacist may be required to conduct medication reviews in hospitals, nursing homes, for Aboriginal Health Services and for private patients. By allowing the pharmacist to be absent from the “registered pharmacy premises” on occasions, the pharmacist will be able to provide a greater range of QUM services to the community.
- The business of the pharmacy may continue without the presence of a pharmacist. Prescriptions may be received and unscheduled and Schedule 2 items may be sold. A credentialed pharmacy technician may be in charge when the pharmacist is absent.
- Schedule 3 items may not be sold without the approval of a pharmacist but changes could allow approval to be given by telepharmacy or other electronic means.
- Schedule 4 & 8 items may be dispensed only under supervision of a pharmacist.
- In the UK the dispensary area of the pharmacy is isolated by some means when a pharmacist is not present.
- In some areas of WA a pharmacy may remain open in absence of the pharmacist but all Schedule 2, 3, 4 & 8 drugs must be locked away.

Recommendation 5

Pharmacists may supervise medication dispensing of Schedule 3 & 4 medications by credentialed pharmacy technicians at remote depots/outstations via video conference or similar technology (telepharmacy).

Rationale:

- Using information technology pharmacists can effectively supervise the dispensing process and counsel patients about their medications.
- Australian pharmacists have a duty of care not only to supply medicines but also to ensure that consumers are provided with sufficient information to facilitate the safe and effective use of medicines, with the intention of optimising health outcomes.¹⁴
- Video conference dispensing or telepharmacy is where the pharmacist can check the prescription and item dispensed by the trained technician, and communicate information to the patient remotely by using

technologies of phone, computers and cameras. Video conferencing of remote dispensing is being used in a number of countries around the world including USA, Canada, Singapore and Sweden. Scanning of bar coded products allow pharmacist to check their computer to ensure the correct product is dispensed.

- Pharmacy depots are legal in Victoria, Western Australia and South Australia. Pharmacy depots are registered premises where patients may leave prescriptions and collect items that have been dispensed at a registered pharmacy under the supervision of a pharmacist, and then transported back to the depot. This requires medications to be sent to the depot from registered pharmacy premises. This system works well in country areas serviced by daily transport from the registered pharmacy. It is not practicable in remote areas because of transport restraints and delays in receiving the dispensed medication. In remote areas it would be necessary for the technicians at the depot to be allowed to dispense.

The Victorian government has subsidised the installation of videophone facilities which will enable a pharmacist in a larger town with a pharmacy to make face-to-face contact and provide essential information on prescription and over-the-counter medicines at pharmacy-owned depots.⁴⁴

- Technology would now enable a pharmacist to be responsible for safe dispensing & patient counseling even when located remotely. Current legislation however does not allow “remote” dispensing practices.

Recommendation 6

Commonwealth Government to employ, and suitably remunerate, a pharmacist for each Aboriginal Health Service.

Rationale:

- The provision of pharmaceutical and cognitive services to AHSs should include not only the dispensing, supply and distribution of medicines but the provision of information and advice about medications and support services to assist with medication management. Pharmacists have a role in providing an education program to the staff of the AHS in accordance with their needs.¹⁵
- Doctors and nurses alike express concern about existing medication practices in remote areas. It is not tenable to have a medicines regulatory system which fails to provide a framework for established, responsible prescribing practice in remote areas. In an increasingly litigious

environment, health service providers are rightly concerned about medicolegal implications and insurers cannot cover “illegal” dispensing.⁸

Recommendation 7

The Commonwealth Government to support and subsidise rapid implementation of electronic prescribing, internet-based communications between health professionals and electronic medical records in remote areas.

Remote areas must have reliable internet access for these electronic medical services to be effective.

Rationale:

- Rural health has much to gain from eHealth, eLearning and eResearch but the relative lack of infrastructure, policies and guidelines have been obstacles to achieving major gains in this area.²⁷
- Electronic prescribing or e-prescribing is when a prescriber sends the prescription electronically directly to pharmacy central hub to be retrieved by patient’s chosen pharmacy.
- Electronic prescribing would improve patient safety, reduce errors and improve efficiency, especially in remote areas.
- Currently, faxed prescriptions are not legal. Yet, the reality for remote pharmacists is that a mailed prescription takes too long, so they work from faxed documents, awaiting the original prescription. There are serious legal difficulties if the prescription does not arrive. It is often difficult to follow up if the original prescription does not arrive, as doctor turnover is extremely high in remote areas. Electronic prescribing will remove the need for the paper chase, thus improving efficiencies for pharmacists, doctors and nurses.
- E-prescribing is about to be launched. It is important that there is provision for a model of e-prescribing where the patient does not have to present at the pharmacy with a barcode or ID card but where the prescriber and dispenser may be directly linked.

Recommendation 8

Legislation of Poisons and pharmacy Acts should be made consistent across Australia to enable safe, seamless cross border practice.

Rationale:

- Cognitive pharmacy services are not mentioned in most state legislation. In 2004 the Northern Territory legislation made a distinction between “pharmacy business” and “pharmacy services”. It is suggested that other states need to do something similar. The pharmacy has a role to play in the community but most importantly the pharmacist is the one with the skills, behaviours and knowledge that leads to improved quality use of medicines. By keeping them “locked” within the four walls of the pharmacy they are limited in the role they can provide within communities that are crying out for experienced health workers.
- State and Territory legislation need to be adjusted to accommodate electronic prescribing and telepharmacy.
- It is not legal to dispense Schedule 8 medicines written by a doctor in another state. In many remote areas the prescribing Doctor may be in another state from the nearest pharmacy. Guidelines and exemptions need to be drafted for pharmacists working in trans-border situations.
- State nursing regulations vary as to who is allowed to dispense what and where. Nurses often are unsure if they are practising within the law. e.g. nurses may be working in WA but dispensing according to CARPA (NT) drug protocols because their AHS is based in NT. Pharmacists have little understanding of the necessary qualifications for dispensing nurses in each state so are unsure as to whether medications are being “legally” supplied from remote clinics.
- To date, many health professionals are crossing state borders and thus needing multiple state health board registrations. This will be rectified by national health professional registration to be introduced in July 2010.
- Pharmacy is frequently overlooked in planning activities aimed at improving the health care system. This may partly be a result of hybrid nature of funding and regulation – the Commonwealth providing funding through the PBS, while regulation about pharmacy ownership and scheduling of medicines is incorporated in state and territory legislation.¹⁸

3 Appendices

Appendix 1: Literature Findings

Introduction

No literature was found relating to legal impediments to remote pharmacy practice in Australia. There is however a small amount of literature relating to supply of pharmacy services to remote areas and a vast body of work outlining Aboriginal and Torres Strait Islander health issues and reviewing the remote health care practices of nurses and medical practitioners. Nurses play an extensive role in the administering of medications in remote areas. Nursing bodies have implemented special credentialing and guidelines for their remote workforce. Many of the issues facing other remote health professionals are relevant to pharmacy and influence effective medication delivery.

Currently, each state or territory in Australia has a pharmacy board and a myriad of legislation which may be difficult to understand by pharmacists. Similarly it appears remote nurses have limited understanding of their legal obligations. Many of the “grey” areas of legality for remote pharmacists have arisen since the commencement in 1999 of the Section 100 arrangements for medication supply to remote Aboriginal Health Services. A number of issues also arise for pharmacists working across state borders.

Remote Health

For the 34% of Australians living in regional and remote areas, overall health status worsens on a continuum as you move away from metropolitan centres. Contributing factors include social and economic disadvantage, poorer access to health care, high levels of health risk behaviours, geographical and environmental issues, historical and social influences on Indigenous communities.¹

Remote health is characterised by geographical, professional and often social isolation of practitioners; a strong multi-disciplinary approach; overlapping and changing roles of team members; practitioners requiring public health, emergency & extended clinical skills; cross cultural health systems, serving populations with relatively high health needs.² Remote health practice in an Aboriginal or Torres Strait Islander community adds a further level of complexity as the practitioner has to relate to cross-cultural communication, differing world views, language barriers and gender issues. Furthermore they will be serving a population with a significantly higher burden of ill health.³

Supply of Medications to Remote Aboriginal Health Services under Section 100

The poor health status of Aboriginal and Torres Strait Islander peoples is well documented. According to the Australian Institute of Health and Welfare the life expectancy of Aboriginal and Torres Strait Islander peoples is significantly poorer than many 3rd world countries, such as Nigeria, Nepal, India and Bangladesh. Improving health outcomes for Aboriginal and Torres Strait Islander peoples requires a multifaceted approach in which it is essential that access to medications is part of the solution.⁴ Despite a higher burden of acute infections and chronic diseases, under-use of medication is evident in the Aboriginal and Torres Strait Islander populations, as highlighted by the statistics comparing PBS spending of Indigenous and non-Indigenous populations.⁵

In 1999 the Australian government introduced free medications for Aboriginal and Torres Strait Islander patients in remote areas under Section 100 (s100) of the Health Act. The implementation of s100 medications for remote area Aboriginal Health Services represents a breakthrough in medicines access but the transfer of dispensing functions from pharmacies to Aboriginal Health Services (AHSs) has raised issues of ensuring Quality Use of Medicines (QUM) and appropriate pharmaceutical support.⁶

Some pharmacists were concerned that s100 arrangements resulted in AHSs giving patients inappropriate medications or poorly labelled medications. Pharmacists were also concerned that some medications were being overused and drug interactions not identified. Labelling of medications often occurred by hand and fell short of legislative requirements. Medication can often be easily accessed by unskilled and unqualified staff.⁷

There is a huge and challenging role for pharmacists and other health professionals to ensure medication safety, concordance and education. The difficulties that Aboriginal and Torres Strait Islander people face in adhering to medication regimens are real. Prescribers need to make the effort to ensure there is a full understanding of the reasons for and the nature of treatment as well as an assessment of likely barriers that patients will face.⁸

Poor QUM in Indigenous communities directly precedes poorer control of chronic disease states and subsequent higher hospital admissions, morbidity and mortality.⁹

The implementation of Section 100 meant that an increasing number of clients with complex conditions were being managed at the Aboriginal Health Service level. Dose administration aids (DAAs) are packed in many AHSs. Issues for AHSs on implementation of s100 included the lack of dispensary capacity, lack of appropriate procedures & protocols, insufficient staff to meet increased workload, less time for clinical care and lack of appropriately trained staff.¹⁰

Under the Third Community Pharmacy Agreement 2000-2005, the Section 100 Pharmacy Support Allowance was set up to assist pharmacists to support the AHSs in their implementation of Section 100 medication supply, and in an attempt to address some of the QUM issues.

The high turnover of Aboriginal Health Workers and nursing staff in remote areas has resulted in pharmacists delivering procedural training rather than clinical and QUM training at Aboriginal health Services. Most pharmacists felt that it was important to get the operational aspects of medication management resolved and spent most of their allocated time and resources in trying to achieve efficient, effective supply.³¹

Under the Fourth Community Pharmacy Agreement (2005-2010) there are enhanced accountability measures and increases in the s100 Pharmacy Support Program allowance.³⁶

Remote Nursing Practices

Advanced nursing practice has seen the specialisation of skills and knowledge. It is marked by a combination of education, experience and the further development of competence. The nurse practitioner role further extends advanced nursing practice and is specifically sanctioned by legislation and professional regulation.¹¹ Practice nurse incentives now include Medicare item numbers for wound dressings, immunisations and Pap smears when performed under delegation.¹²

Rural and remote registered nurses have an advanced practice role that can encompass a wide range of responsibilities. Some of these responsibilities exceed legal boundaries with the risk of compromising the safe care of clients. Many rural and remote nurses assume the responsibility for the ordering, possession, storage, initiation, administration and supply of medications as part of their normal duties. In order for safe use of medications to occur appropriately, approved and authorised protocols explicitly describing practice must be in place. In addition to registered nurses and their employers, medical practitioners and pharmacists also have a responsibility to ensure the safe use of medications in a practice setting.¹³

Doctors and nurses alike are worried by existing medication practices in remote areas. It is not tenable to have a medicines regulatory system which fails to provide a framework for established, responsible prescribing practice in remote areas. In an increasingly litigious environment, health service providers are rightly concerned about medicolegal implications and insurers are unable to cover "illegal" dispensing.⁸

Nurses constitute the largest group in the rural and remote health workforce. In many smaller towns and communities nurses are supported only by on-call or

part time medical offices and allied health staff. However there is an emerging crisis in rural and remote area nursing, exemplified by nursing shortages and the ageing of the nursing workforce.¹¹

Remote Pharmacy Practice

Australian pharmacists have a duty of care not only to supply medicines but also to ensure that consumers are provided with sufficient information to facilitate the safe and effective use of medicines, with the intention of optimising health outcomes.¹⁴

The Pharmaceutical Society of Australia (PSA) states that it is committed to promoting Quality Use of Medicines (QUM) in Indigenous communities through improved access to the services and expertise of pharmacists. The provision of pharmaceutical and cognitive services to AHSs should include not only the dispensing, supply and distribution of medicines but the provision of information and advice about medications and support services to assist with medication management. Pharmacists have a role in providing an education program to the staff of the AHS in accordance with their needs.¹⁵

And yet there is some feeling in remote Australia that often the pharmacists' role is "Supply, supply, supply and visit occasionally".¹⁶ Remoteness brings its own challenges with travel by plane or dirt road not only consuming monetary resources but also significant amounts of time and frustration.³¹ Constraints of distance, time, finances and the existing pharmacy service models mean that pharmacists have little time for rapport building and providing culturally safe healthcare.

Stoneman and Taylor argue that the danger of suboptimal QUM will remain until issues relating to remuneration of pharmacists are addressed and adequate training of Aboriginal Health Workers achieved.¹⁷ Increases in remuneration have recently occurred but pharmacy services to remote areas still consist mainly of supply, stock auditing and cold chain management. Innovative pharmacy service models need to be implemented and legal anomalies need to be addressed to encourage greater QUM initiatives to be implemented.

The Clinical Pharmacists' Roles

Medicines if used appropriately are cost effective. They improve health outcomes and quality of life and avoid costs caused by further medical treatments and hospitalisations.

Pharmacists as medicine experts are seen as the most appropriate health professionals to run medication compliance and monitoring programs to improve the outcomes for their patients.¹⁸ It is well recognised internationally that the provision of medication education to clients has several benefits to both the client

and the health system as educated clients are capable of making informed decisions. Adequate knowledge of medications has been shown to decrease repeat presentations.¹⁹

There is strong evidence showing the burden of medication misadventure in Australian hospitals. Pharmacy services play an integral role in minimising the risks of medication misadventure. A safe and effective medication supply process that involves both prescription review and counselling of the patient is vital in maintaining a high quality and safe health-care system.²⁰ A number of studies demonstrate a positive effect on diabetes and/or hypertension outcomes by involving a pharmacist in the primary health care team.^{21, 22}

Lack of medication counseling and essential information often leads to failure of the patient taking the medicine correctly, which can in turn lead to therapeutic failure or unwanted/dangerous effects from drugs.³⁸

Although pharmacists add value by professional counselling in dispensing and supplying of all scheduled products, pharmacy is frequently overlooked in planning activities aimed at improving the health care system. This may partly be a result of hybrid nature of funding and regulation – the Commonwealth providing funding through the PBS, while regulation about pharmacy ownership and scheduling of medicines is incorporated in state and territory legislation.¹⁸

Workforce Issues

There has been a shortage and serious misdistribution of pharmacists in rural and remote areas. However, in 2007 there were 1,427 pharmacy school graduates. This is a doubling of graduate supply in the last 10 years. There is also strong growth in supply from immigration.²³ With the Australian Government (Dec 2. 2008) pledging \$2.7 million in grants to help support, train and educate rural health professionals, it is hoped that some of the new graduates might choose work in rural and remote areas. Do we need new models of practice and employment structures to entice new graduates to rural areas to deliver clinical services?

Remote Pharmacy Practice Initiatives Supply

- *Prescription Depots/Distance Dispensing*

Prescription depots are now legal in Victoria and South Australia. They are also used in Sweden where prescriptions are emailed to the pharmacy and medications delivered by courier to the depot.

PSA Professional Practice Standards (2006) state that when distance dispensing occurs a CMI or written information should be supplied and all consumers should be telephoned when the medicine is dispensed for the first time to ascertain

whether they understand how to take medicine and explain any potential side effects.²⁴

- *Vending machines*

Vending machines are being used in the USA to dispense prescription and non-prescription medicines. From afar, pharmacists send a message from their computer telling the machine which prepackaged bottles of pills to dispense. A staffer at a clinic retrieves the bottle, affixes a label, and gives it to the patient.²⁵ The greater uptake of robotics into pharmacy may see improvements to safety and quality in the dispensing process.²⁶

Professional Practice

- *Telepharmacy*

Rural health has much to gain from eHealth, eLearning and eResearch but the relative lack of infrastructure, policies and guidelines have been obstacles to achieving major gains in this area.²⁷ Telepharmacy is an application of telehealth. In the US and Canada, telepharmacies staffed by registered pharmacy technicians and registered nurses use cameras to contact pharmacists in other locations who then check prescription, product, label and conduct a patient consultation.^{28, 29}

- *Pharmacist Prescribing*

Pharmacists are the most accessible providers of health information, have roles in health promotion, medication review and disease state management. Pharmacists have extensive training in pharmacology, therapeutics, disease state management and communications skills. The extension of prescribing rights to pharmacists has the potential to optimise medication management, improve continuity of patient care and improve patient access to medication.²⁸

In the UK limited prescribing is now being done by pharmacists. This facilitates patient access to medicines and relieves some of the workforce pressures on doctors and nurses. Limited prescribing rights are being given to other health professionals such as nurse practitioners, optometrist, dentists and others. A pharmacist should be given limited rights for “continuity prescribing” e.g. writing repeats following an initial GP diagnosis for a limited period. The health care system copes well with managing acute conditions but is less effective at managing chronic conditions. A GP’s time is overstretched and patients with chronic conditions often are not able to access an ongoing treatment plan.¹⁸

Prescribing medications is not a simple process and requires more than knowledge of a drug indication. Knowledge of adverse effects, doses, optimal routes, drug-drug and drug-food interactions, pharmacokinetics and monitoring of effects is needed, and application of this knowledge requires significant expertise – expertise that pharmacist’s possess.³⁵

The Bessell, Emmerton, Marriota and Nissen study in 2005 examined the varying types of pharmacy prescribing around the world and developed a number of pharmacy practice models for Australia.³⁵

- *Increased Pharmacist scope of practice*

Innovative pharmacy practice in US includes anticoagulation management, diabetes self-management, cholesterol management, hepatitis C education, dietary supplement consultations, medication management and review, immunisation, smoking cessation, compounding, renal, psychiatric and oncology pharmacy.

A small, but growing number of community pharmacies in the USA have established successful niches in immunisation, creating a template of preparation, marketing, operation and follow-up.³² In Australia nurses can attend specialised immunisation accreditation courses so that they may administer immunisations without a doctor's order (within state of accreditation). Pharmacists could specialise and be credentialed to immunise.

In 1990 15% of the USA Indian Health Service (HIS) received their care from pharmacy practitioners. The HIS pharmacists managed patients with selected disease states including otitis media & externa, urinary tract infections, venereal disease, congestive heart failure, hypertension, seizures, bacterial and fungal infections, arthritis, immunisations, back pain and conjunctivitis.³⁵

The Pharmaceutical Society of Australia supports the development, training and credentialing of specialist practitioners in the pharmacy profession. In pharmacy, as in all medical and allied health practice, specialisation has become essential to optimal patient care. A "specialist practitioner" refers to a pharmacist who has been credentialed in a speciality practice area by demonstrating an enhanced or advanced level of knowledge, skills and experience in that area. The pharmacist's professional roles and responsibilities will continue to evolve, expand and diversify. This process is occurring in an environment where other health professionals are similarly seeking to redefine their roles as systems for delivery of care change.³⁰

Remote pharmacy practice should be a defined speciality. Like Adherence Support Workers in Zambia, Aboriginal Health Workers in Australia can play a huge role in assisting with patient medication adherence and patient education but they need to receive relevant, practical and accessible training. Pharmacists need to embrace their role as medication educators.

Clinical Pharmacy models³⁰

The current pharmacy ownership structure and the lack of payment of pharmacists for clinical services, restrict the delivery of pharmaceutical services.

Whereas, practice nurse incentives now include Medicare item numbers for wound dressings, immunisations and Pap smears when performed under delegation,¹¹ there is no such model for a pharmacist. Home Medicines Review (HMR) is the only pharmacy service where remuneration is claimed through a Medicare item number.

To date most pharmacists have either been employed by community pharmacy or the state hospital system. Other allied health professionals have “sessional” award rates for delivery of clinical services. Sessional payment for clinical advice should be considered as a mode of payment/employment for pharmacists.

Slowly, some innovative models of practice are being developed. There are now a handful of pharmacists in Australia being funded by Aboriginal Health Services, the Office of Aboriginal and Torres Strait Islander Health (OATSIH) and General Practice Networks, to deliver clinical pharmacy services to remote Aboriginal and Torres Strait Islander communities. Aboriginal and Torres Strait Islander people who form a relationship with the pharmacist have reported improved health as a result.³¹

As Professor Lloyd Sansom lamented at Pharmacy Australia Congress, Perth 2008, “the current framework, which is heavily structured on drug distribution, restricts the innovation and development in pharmacy practice which will promote this profession as a legitimate partner in new primary health care delivery models, rather than being seen simply as a distributor”.

Literature Summary

Australian pharmacists have a duty of care not only to supply medicines but also to ensure that consumers are provided with sufficient information to facilitate the safe and effective use of medicines, with the intention of optimising health outcomes.¹⁴ In fact Australian Government policy on QUM states: “to achieve quality use of medicines, people must be provided with the most appropriate treatment and have the knowledge and skills to use medicines to their best effect”.³³ Yet most of remote Indigenous Australians are still not receiving appropriate skills or knowledge for the safe, effective use of medicines.

Improved access to medications through the Section 100 supply arrangements has improved access but it is untenable to have a system of pharmaceutical supply which delivers inadequate quality use of medicine services.

Currently, good clinical care of patients in remote areas is inhibited by legislation that is historically based. The legislation impedes high standards of pharmaceutical care. Patients living in remote areas should have equitable, if not higher, standards of medication safety. Pharmacists in remote areas face added challenges and should be given assistance to deliver high quality clinical care.

Remote Rural Pharmacists Project

This project concentrates on examining the bureaucratic and legislative barriers to good pharmaceutical care.

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Appendix 3: Interview Findings

Five Expert Reference Group members were consulted. Twenty eight pharmacists, with an understanding of remote practice were contacted and semi-structured interviews conducted.

The pharmacist interviews consisted of twenty phone and seven face-to face contacts and one week of experiential learning in the Central Desert, WA. The pharmacists contacted consisted of 4 hospital pharmacists, 11 community pharmacists, 3 pharmacists employed by Aboriginal Health Services, 3 pharmacy academics, 4 pharmacy consultants and 2 representatives from national pharmacy organisations. All but 2 of the community pharmacists supplied medications to remote Aboriginal Health Services under the Section 100 agreement. The geographical split was 2 in NSW, 1 in Victoria, 2 in Tasmania, 6 in Queensland, 1 in South Australia, 4 in Western Australia and 11 in the Northern Territory.

Results

There were 2 distinctive schools of thought. The community pharmacists did not perceive that there were many legal barriers to medication supply, although many logistical and economic barriers. They did identify faxed scripts and restriction to their pharmacy premises as issues. The other pharmacists interviewed identified a myriad of conflicting regulations. The regulatory impediments did not always prevent the pharmacists from delivering medications and cognitive services, but much concern was expressed about onus and responsibility if there was an error or problem. Most of the pharmacists did not have a clear understanding of regulations in their state.

Listed below are the pharmacists' concerns, questions and comments:

- Why is a pharmacist not able to dispense in a premises which is not registered as a pharmacy when less qualified nurses and AHWs are?
- I'm not sure if I'm allowed to pack/repack a dosette (DAA) when I visit a clinic, which is outside a registered pharmacy.
- Am I legally covered if I give out medication at a patient's home?
- Do Schedule 8 (S8) prescriptions need to be written by doctor and dispensed by pharmacist? Often the nurse writes the orders for an S8 medication and the doctor signs it. Is this legal?
- Are faxed prescriptions legal? Often an original prescription is never sent or is lost in the mail. The high turnover of doctors makes it impossible to chase up missing scripts. Is the doctor or pharmacist responsible?
- Nurses and other professions may be dispensing medications, yet not be qualified to do so. Whose responsibility is it in the event of a mistake? Mostly, there is no doctor present.
- Pharmacy ownership laws do not allow ownership of a pharmacy by an Aboriginal Health Service (except in NT). This limits the number of

- pharmacists in remote areas. If an AHS accrued the profits from a pharmacy then it could afford to employ pharmacists.
- Cognitive pharmacy services – what are the legal implications? Can I legally give medication advice or do a wound dressing at a patient's home?
 - I cannot leave the pharmacy if I need to visit a nursing home, a patient, the hospital, an AHS or attend medication management meetings.
 - Why does a pharmacy need a pharmacist present to sell a Schedule 2 item and yet the same product can be sold in a service station or supermarket 100kms up the road?
 - The Poison Permit held by the AHS may be out of date or not be relevant for what the AHS is doing. People not specialising in medications, and with little understanding of the issues, may be in charge of the Poisons License. Am I as the medication supplying pharmacist responsible if the Poison License is not up to date?
 - Poisons permits may cover the facility to store and supply, but do they cover dispensing? The pharmacy regulations mean a pharmacist cannot dispense.
 - Low literacy levels mean it is difficult for patients to sign and date prescriptions. The HIC will not pay if we get the patient to use a date stamp.
 - Low literacy levels mean that Consumer Medication Information sheets (CMI) are inappropriate. Do we still have to give out CMIs?
 - Cold chain requirements are not always adhered to by clinic staff. Who is responsible?

Interstate Issues

- It is not legal to dispense S8s interstate. The prescribing doctor may be interstate or the patient may be interstate from the pharmacy. Should we supply the S8 medication to the patient? Which state's legislation is to be followed?
- Doctors, pharmacists & nurses require multiple registrations if working in more than one state. How would a pharmacist know where the doctor is registered?
- Nurses' regulations vary – who is allowed to dispense what, where? Nurses don't know if they are practising within the law e.g. nurses may be working in WA but dispensing according to CARPA (NT) drug protocols because their AHS is based in NT. As a pharmacist I have little understanding of which nurses are qualified to dispense or prescribe e.g. WA nurses are allowed to do standing order prescribing only if they have completed a remote pharmacology course. Does a supplying pharmacist need to know what a nurse's qualifications are?
- What are the labelling regulations in each state? If the nurse/AHW does not label according to regulations, is the supply (s100) pharmacist legally responsible?

- Why are pharmacy Depots/outposts allowed in some states but not others?

Duty of Care Impediments

- At one Aboriginal Medical Service they will not allow me to access the patient records because of patient confidentiality rules, as interpreted by the medical service.
- There is a high turnover of doctors, nurses and other staff in remote areas.
- It is not financially viable for me to deliver HMRs & RMMRs because of travel time & costs.
- The current HMR model doesn't work. The fly in, fly out doctor doesn't know the patients. Aboriginal and Torres Strait Islander patients are often not available to come back for an appointment. The pharmacy, to which referral may be sent, has no connection with the patient.
- Indigenous aged care facilities cannot be accredited under the government's current guidelines because the guidelines don't fit e.g. Aboriginal and Torres Strait Islander people don't want to have single rooms and do want to have their dogs wandering around. Because the aged care facility is not government accredited I cannot claim remuneration for doing RMMRs.
- My rural community pharmacy in rural areas supplied the local hospital. It is not viable for me to keep specialised, high cost products in stock. Is there a legal requirement to keep life saving medications in stock?
- The Section 100 Support Allowance is not sufficient for me to visit my remote communities regularly and thus it is impossible to build patient rapport and provide clinical services.
- I can't get away from my pharmacy to visit the remote communities I supply because I can't get/can't afford another pharmacist.

Section 100 clinics/drug rooms

All s100 support pharmacists felt that the health clinics and drug rooms were now reasonably well organised and that drugs were stored under appropriate conditions. They expressed some concern as to whether dispensing, filling of dosette boxes and labelling regulations were always adhered to by clinic staff. High staff turnover in clinics was recognised as a continual, ongoing problem. The pharmacists all complained that travel, time and cost were limiting factors that meant they only usually visited communities twice a year. When visiting the communities the pharmacists spent their time in stock control and procedural issues. Very little medication training was carried out with staff.

A number of s100 supply pharmacies had moved to dispensing medication with labels and DAA packing at the pharmacy, despite only being remunerated for supply and not dispensing. They felt that dispensing at the pharmacy helped to minimise errors.

Broadening the scope of a pharmacist's practice

Only one of the pharmacists interviewed was keen to broaden his scope of practise into things such as immunisation. All other remote pharmacists felt that there was more than enough work to do in the medication field without taking on further responsibilities. They felt that it was better to leave immunisation to remote nurses who had training in this area and who were more plentiful than pharmacists. "Pharmacists should stick to their area of expertise", was a common sentiment.

Opinions of current legislation – Quotes from Remote and rural pharmacists

"I don't really know what is legal. There are too many different regulations. We just do what we think is responsible, which I guess is OK as long as no one makes a mistake."

"There is no definition of what a pharmacist does, other than limited access, storage & safe supply of medications."

"Current laws tie the pharmacist to the dispensary bench."

Appendix 4: Legislation Issues

State pharmacy legislation was examined; pharmacy boards and state health regulatory bodies were contacted.

Pharmacy legislation, like pharmacy structure, has an historical base and relates mainly to medication supply. There are a number of legal constraints inhibiting the delivery of clinical pharmacy services and these are listed below.

Pharmacy practice is governed by both state and commonwealth legislation. There is a myriad of confusion amongst pharmacists, health regulators and some pharmacy board delegates. The summary of legal impediments below is defined as understood by the author. However, many of the regulators' responses have been conflicting and it is suggested that further legal opinion be sought.

Legislation Impeding Pharmacy Practice

Dispensing from registered premises

In most states, pharmacists are unable to obtain or dispense a restricted substance, except at a registered premises i.e. a pharmacy.

At outpost clinics in Queensland, NSW, and Western Australia, nurses and Aboriginal Health Workers are dispensing medications but pharmacists, the most qualified health professional for this role, are prohibited from dispensing.

The different state laws are listed below. The laws of Tasmania and Victoria are not outlined as they have no outposts that are considered "remote" for the purposes of this project.

WA Act. : A pharmacist is prohibited from supplying a scheduled substance from anywhere except a registered pharmacy.

SA Pharmacy Practice Act 2007 sect 37: A person must not provide restricted pharmacy services except at premises registered as a pharmacy or pharmacy depot.

NSW Pharmacy Practice Act 2006 section 23: A person may not carry on a pharmacy business unless the premises on which the pharmacy business is carried on are the subject of a current approval of the Board.

Qld Health (Drugs and Poisons) Regulation 1996: To the extent necessary to practice pharmacy a pharmacist is authorised to obtain, dispense, sell a restricted drug (other than by wholesale) on a purchase order or possess a restricted drug at a dispensary or institution where a dispensary is defined under the *Health Regulation 1996*.

The Packing of Dose Administration Aids (DAAs)

The packing of DAAs outside a pharmacy is a fairly “grey” area of legality. It appears that in the NT and WA, the packing of DAAs is seen as supply, not dispensing and thus can be done by anyone, anywhere as long as medication has been dispensed. In NSW a pharmacist can fill a DAA outside a pharmacy if the medication has been dispensed within a pharmacy. The question here is does Section 100 “supply” count as dispensing? Nobody interviewed was certain of the answer. In SA and Queensland, the packing of DAAs by a pharmacist must be done within registered premises (pharmacy).

Restriction to Premises

In all states it is required that a community pharmacy is under the direct supervision of a pharmacist at all times while open to the public.

Supply of Schedule 8 substances (S8s)

The prescribing, dispensing and storage of S8s have stringent requirements in all states to reduce the risk of fraud and misadventure. An S8 prescription may not be dispensed interstate. Regulations pertaining to supply of S8 medications by nurses and Aboriginal Health Workers vary in each state and are not well understood.

The continual supply of Schedule 8 poisons requires a permit after eight weeks of treatment in non-drug dependent patient. This usually requires GP peer review. This is very difficult where there is a scarcity of GPs. Authority prescriptions and related paperwork records are often difficult to retrieve in remote areas where doctor turnover is high.

Faxed Prescriptions

Original prescriptions must be received before medication is dispensed or within 24 hours of medication being dispensed in most states.

Labelling

Pharmacists must abide by strict medication labelling guidelines. Labelling must include: Name, strength and description of the medication; the dosage form, dose, route of administration and duration of therapy; correct storage information, expiry date and batch number; and the initials of the pharmacist taking responsibility.

Labelling guidelines for nurses vary in each state and are poorly understood by nurses and pharmacists.

Residential Medication Management Review

Many Aboriginal Aged Care Facilities are not government accredited. When a facility is not government accredited a pharmacist cannot claim for an RMMR. The Pharmacist however can carry out an HMR in such a facility, but needs a GP referral.

Aboriginal Health Service Responsibilities

Poisons Permit

An Aboriginal Health Service needs a Poisons License to order & store medicines. The Drug & Poisons laws in each state and territory have different requirements. In some, but not all states, the holder of the poisons licence must be the doctor or pharmacist.

Section 100 medication supply

AHSs are supposed to ensure that the medicine room is kept at an appropriate temperature and that cold chain standards are adhered to. Thus they must be able to ensure a reliable power supply. The dispensing & filling of DAAs must occur in a clean, uncluttered area and medications should be labelled. Adequate medication record keeping should occur and medication should be appropriately secured.

The Aboriginal Health Service is responsible for supplying the medicines to patients in a safe and appropriate way and in accordance with relevant legislation. The s100 pharmacist, as part of their service, should ensure staff involved in the supply of pharmaceuticals are aware of their legal obligations in possessing, administering, prescribing and dispensing medications.³⁴

Appendix 5: Legislation List

Jurisdiction	Pharmacy Practice Acts and Regulations	Poisons Acts and Regulations
Vic	Health Professions Registration Act 2005 Health Professions Registration Regulations 2007	Drugs Poisons and Controlled Substances Act 1981 Drugs Poisons and Controlled Substances Regulations 2006
NSW	Pharmacy Practice Act 2006 Pharmacy Practice Regulation 2006	Poisons and Therapeutic Goods Act 1966 Poisons and Therapeutic Goods Regulation 2008
Qld	Pharmacist Registration Act 2001 Pharmacists Registration Regulation 2001 Health Practitioners (Professional Standards) Act 1999 Health Quality and Complaints Commission Act 2006 Health Services Act 1991 Health Services Regulations 2002	Health Act 1937 Health Regulation 1996 Health (Drugs and Poisons) Regulations 1996
SA	Pharmacy Practice Act 2007 Pharmacy Practice Regulation 2007 Health and Community Services Complaints Act 2004 Health and Community Services Complaints Regulations 2005	Controlled Substances Act 1984 Controlled Substances (General) Regulations 2000 Controlled Substances (Poisons) Regulations 1996
WA	Pharmacy Act 1964 Pharmacy Act Regulations 1976	Poisons Act 1964 Poisons Regulations 1965

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Tas	<p>Pharmacists Registration Act 2001</p> <p>Pharmacists Registration Regulations 2007</p> <p>Health Complaints Act 1995</p> <p>Health Complaints Regulations 1995</p>	<p>Poisons Act 1971</p> <p>Poisons Regulations 2008</p>
ACT	<p>Health Professionals Act 2004</p> <p>Health Professionals Regulations 2004</p>	<p>Medicines, Poisons and Therapeutic Goods Act 2008</p> <p>Medicines, Poisons and Therapeutic Goods Regulations 2008</p>
NT	<p>Health Practitioners Act 2004</p> <p>Health and Community Services Complaints Act</p> <p>Health and Community Services Complaints Regulations</p>	<p>Poisons and Dangerous Drugs Act</p> <p>Poisons and Dangerous Drugs Regulations</p>
Cth	<p>National Health Act 1953</p> <p>National Health (Pharmaceutical Benefits) Regulations 1960</p>	<p><i>Therapeutic Goods Act 1989</i></p> <p><i>Therapeutic Goods Regulations 1990</i></p>