



HEALTHCARE MANAGEMENT ADVISORS

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**ACCESS TO MEDICINES CONSORTIUM**

**Consumer Access to Prescription Medicines:  
Identifying the Barriers**

**FINAL REPORT**

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# Executive Summary

## BACKGROUND

Healthcare Management Advisors (HMA), in association with the Chronic Illness Alliance, was appointed by the *Access to Medicines Consortium* (the Consortium), to conduct research into identifying the barriers affecting consumer access to prescription medicines in Australia.

The first phase of a longer term work program being undertaken by the Consortium, this preliminary study has sought to identify and quantify the impact of these different consumer barriers to access across a variety of demographic and socio-economic groups.

Specifically, HMA has examined the situation in relation to seven consumer groups which were named in the initial tender brief as being at particular risk of experiencing restricted access to pharmacy medicines. These groups are:

- (1) people with a chronic illness
- (2) people with a mental illness
- (3) people with a disability, including physical and intellectual disabilities, and acquired brain injuries;
- (4) indigenous people;
- (5) people living in rural and remote areas;
- (6) people from Culturally and Linguistically Diverse (CALD) backgrounds;
- (7) people on low incomes.

Based on an agreed Project Plan, the project methodology involved the following stages:

- (1) **Conducting a Situation Analysis.** We gained input from an initial meeting with the EAG, a literature review and preliminary data analysis.
- (2) **Obtaining Stakeholder feedback.** Through a telephone interview process we sought key stakeholders' views about our preliminary assessment of barriers to access for each population group. At the conclusion of this stage, a comprehensive draft description of the access barriers, access indicators by population group and a preliminary list of research priorities for each population group was identified.
- (3) **Developing a list of research priorities.** The preliminary list of research priorities was considered by representatives of the EAG at a 'brainstorming' session held on 20 June 2005. This session prioritised the list of research opportunities. As a result of that session, HMA was asked to develop research proposals for four high priority projects.
- (4) **Final report.** A final report (this document) brings together the findings from the previous project stages.

## DEFINITION OF ACCESS BARRIERS

In undertaking our analysis, HMA has relied on a World Health Organisation Forum definition of access to health services: an *individual[s] right and ability to obtain care when needed*. We have also sought to identify (and group) individual barriers affecting consumer access to medicines under the following key areas:

- *physical availability*: the type and quantity of product or service needed, and the type and quantity of product or service provided;
- *affordability*: the relationship between prices of the products or services and the user's ability to pay for them;
- *geographical accessibility*: the relationship between the location of the product or service and the location of the eventual user of the product or service;
- *acceptability*: the fit between the user's attitudes and expectations about products and services and the actual product and service characteristics; and
- *quality of products and services*.

## LITERATURE SURVEY

The literature review was conducted by members of the HMA team in consultation with our specialist advisors. The literature search encompassed both peer-reviewed journals and other published literature. Electronic database searching, communication with Australian experts in the field, Internet searches targeting individual organisations and government web sites were among the key approaches used to identify literature relevant to this study.

Overall, we found that there was relatively limited literature on barriers to accessing medicines encountered by consumers. The limited literature that does exist identified the following themes:

- (1) Physical barriers may include a lack of pharmacy services in a particular area or lack of public transport for people to travel to a pharmacy. Co-location of pharmacies with medical practices has been shown to improve accessibility.
- (2) Affordability of drugs is the main barrier to accessibility for people both in Australia and internationally. This is particularly the case for those on low incomes, people with chronic illness and in some cases for people who live in geographically remote areas and unable to afford transport. Financial difficulties frequently cause people to change their medication purchasing or taking behaviour meaning that their medication regime is less effective.
- (3) Geographic barriers are particularly relevant for Aboriginal people living in remote areas of Australia but people living in rural communities in other countries may also suffer from a lack of access to pharmacies especially where workforce or other issues cause local pharmacies to close.
- (4) Barriers relating to acceptability of medicine supply include lack of availability of language appropriate or culturally appropriate information about medicines. Elderly

people with cognitive impairment have also been found not to access medicines as readily as people without cognitive impairment. The literature reviewed demonstrates that the skills of those dispensing medications may impact on the appropriate use of medications (especially where medications are dispensed by non pharmacists). Where the pharmacist is remote from the patients, a lack of counselling and information about the use of the medications can create barriers to the appropriate use of medications.

## **ROUTINELY COLLECTED DATA**

The research brief required HMA to analyse publicly available data sources such as the National Health Survey, the Disability and Carers Survey (SDAC), the Household Expenditure Survey (HES) and National Morbidity Data. The objective of this component of the project was to identify what data is routinely collected that could also inform the future research agenda of the *Consortium*

### ***Conclusions from National Health Survey data.***

There is evidence from the data of the National Health Survey to suggest that the types of illness and treatments sought for illness may differ depending on socio-demographic backgrounds. In particular it appears that:

- medical treatment sought may be influenced by employment, geographical location, income and type of illness;
- medications used may be influenced by employment, cultural background and type of illness;
- types of illness (long term) may vary across different employment or income status or cultural background; and
- indigenous Australians are generally less healthy than non-indigenous Australians, which may be influenced by geographical location.

The reasons for the socio-demographic differences were not explored in the context of the National Health Survey, but do imply that there may be various needs and barriers to accessing medication across these groups that ought to be identified.

Consistent with these findings, the National Health Strategy published a paper in 1992 ('Enough to make you sick: How income and environment affect health')<sup>1</sup> which highlighted similar issues from previous data sources (the NHS (1989-90), SDAC (1989), ABS Death Data (1985-87), and National Heart Foundation Risk Factor Prevalence Survey (1989)).

Along with these issues the National Health Strategy paper highlighted socio-economic status as a major factor for health status amongst Australians. In particular, the paper noted that compared to people of high socio-economic status, people of low socio-economic status made greater use of primary and secondary health services (such as

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<sup>1</sup> Mathers, C., *Enough to make you sick: how income and environment affect health*, Research paper No. 1, National Health Strategy, 1992.

hospitals, outpatient clinics and doctor visits) and less use of preventative and dental services.

### ***Conclusions from Disability, Ageing and Carers Survey (SDAC)***

There is sufficient evidence from SDAC to suggest that people with disabilities generally have less education, are non-employed and earn significantly less than people without disabilities. This indicates that financial status is a possible barrier to medication access for people with disability.

### ***Conclusions from Household Expenditure Survey (HES)***

The HES data highlights that socio-demographic background influences medical and health care expenditure. In particular:

- couples with 3 or more children spend less than average on medical and healthcare costs, but more than average on food;
- lower income earners spend more on medical and health care expenses than average; and
- cultural background may affect medical and health care expenditure with people originating from Italy and Vietnam spending 2/3 the average expenditure and people originating from the Netherlands spending 1.5 times the average.

### ***Conclusions from Hospital Morbidity Data***

The statistical analysis indicated that for all but one of the *Potentially Preventable Hospital Admission* (PPH) categories there was enough variation between data cells to indicate the cell's *Socio-Economic Index for Area* (SEIFA) decile and *Australian Standard Geographical Classification* (ASGC) remoteness categories were significant (for full report see Appendix A)<sup>2</sup>. This indicates that there are statistically significant differences between potentially preventable hospital admissions of people in varying regional locations and of varying socio-economic status. These findings indicate that economic status (i.e. financial income) and regional location *may* form a barrier to consumer access to medication for potentially preventable admissions.

## **STAKEHOLDER TELEPHONE CONSULTATIONS**

HMA conducted telephone interviews with key stakeholders identified by the EAG in the project planning phase, encompassing representation from all 7 targeted population groups. To re-iterate, these were: people with a chronic illness; people with a mental illness; people with a disability (including physical and intellectual disabilities and acquired brain injuries); indigenous people; people living in rural and remote areas; people from Culturally and Linguistically Diverse (CALD) backgrounds; and people on low incomes.

A list of the organisations/key informants approached for consultation is provided in Table 4.1, the questionnaire format used is at Attachment B and reports on the 18 individual interviews conducted is at Attachment C.

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<sup>2</sup> Analysis performed by TRC Mathematical Modeling.

The key findings to emerge from these consultations were:

- (1) There were no barriers to access that arose which did not fit within the four key access measure categories of Affordability, Accessibility, Availability and Acceptability. The initially indicated measure of *quality of products and services* is one which permeates all areas and did not warrant treatment as a separate category.
- (2) Whilst the broad measures of Affordability, Accessibility, Availability and Acceptability affect all groups, the extent to which 'micro' elements/issues within these measures impact on individual population groups varies markedly. This absence of commonality is highlighted by the fact that respondents from the different groups (as well as respondents from within the same group) ranked the four key access measures very differently in terms of their relative importance to the stakeholder group they represented.
- (3) The key point here is that it *can never be assumed* that the prime set of barriers affecting eg one chronic illness will be the same as another chronic illness, or that one CALD community face the exact same problems as the next. There are quite simply too many variables at play.
- (4) With respect to Accessibility, the level of ease or difficulty people experienced in accessing prescription medicines is *not only* governed by geographic proximity to dispensing services *but also* prescriber services - they are both inextricably interlinked.
- (5) In addition to GPs, 'prescriber services' also includes access to specialists on two levels. Firstly, specialists' expertise in being able to diagnose and professionally treat specific conditions; and secondly, the fact that there are certain (and increasing numbers of) medications which can *only* be prescribed by a specialist. Here, the point needs to be made that a patient needing treatment from a neurologist who is 500km away gains little from living 2 minutes away from a GP, and vice versa.
- (6) In addition to pharmacies, 'dispensing services' also includes other mechanisms for prescribed medicines supply, such as Section 100 Aboriginal Health/Medical Service outlets, remote area nurses, hospital dispensaries and Royal Flying Doctor Service 'Medical Bags/Boxes'.
  - Trends impacting on the acceptability of current models of service delivery: a number of trends that are occurring in the Australian community have been raised during the telephone consultations and warrant consideration as potential barriers. These are:
  - Australia is becoming an increasingly multicultural society with new CALD groups emerging all the time eg Iraqi, Horn of Africa, Afghan. The health industry needs to be responsive to these communities needs to access medicines in a speedy, responsive and sensitive manner.
  - Growing numbers of people throughout Australia are becoming interested in self-medication and self-management of their condition. This has to a very large extent arisen due to consumers having greater access to information via the internet (and media), and a vastly increased awareness (and belief in) using



natural, non-drug product alternatives to prescription medicines. This escalating trend shows no signs of stopping – which is not only reflected in the burgeoning market for dietary supplements, complementary medicines and natural products that promote personal and sustainable wellbeing, but in some peoples’ reluctance to use prescription medicines. Put simply, many people are no longer interested in just *treating* ailments and illnesses, but in leading healthier lifestyles, eating ‘better-for-you’ foods and doing all they can to *prevent* health problems from occurring. Given the trends above and insights we have gained from our study, there is a compelling case to say that ‘Alternatives’ to prescription medicines may be a fifth access consideration factor. The rationale behind this is that as preference and confidence grows in using natural products and self-management to maintain good health, there is a very real chance that it will become an increasingly bigger barrier to people even *wishing* to access prescription medicines – whether they are affordable, geographically accessible and readily available or not.

## **SYNTHESIS OF FINDINGS AND NEXT STEPS FOR RESEARCH**

At a brainstorming workshop on 20 June 2005 representatives of the *Access to Medicines Consortium* examined a list of 38 *future pointers for research* developed by HMA in response to the issues raised in telephone consultations.

Based on an analysis of the future research pointers it was concluded that the consultation process had not identified any significant new issues or gaps in thinking about access barriers confronted by consumers *at a micro level*. Furthermore, it was observed that most of the *research pointers* were being or could be addressed by key stakeholders with prime program responsibility in the area eg the Guild, the Department of Health and Ageing.

The *Access to Medicines Consortium* defined its research brief in relation to consumer access barriers as being to:

- leave stakeholders with prime responsibility for managing an existing program to respond to access concerns in relation to that program. The *Consortium* will monitor what progress is being made to address any problems; and
- intervene to ensure research on access is undertaken where:
  - there is no primary stakeholder on an issue; or
  - ‘multiple needs’ groups are impacted; or
  - it is not easy to put processes in place to examine or progress an issue.

The *Access to Medicines Consortium* members identified four high priority areas where research is required in the short term that meet these research criteria. These are:

- High priority #1: re-designing aspects of the PBS and MBS safety net to better address affordability;
- High priority #2: promoting enhanced medication access and management processes for complex care patients;

- High priority #3: medicines access – identifying the impact of macro drivers of demand – income, geography, socio-economic status; and
- High priority #4: facilitating access to medicines by homeless people.

The rationale for undertaking this research, and a preliminary specification of each task, is presented. The *Access to Medicines Consortium* proposes to take a leadership role in these areas. It will seek funds to pursue this work. Evidence gained from the research will enable policy settings to be reviewed and reformulated with the goal of promoting enhanced consumer access to medicines.