



HEALTHCARE MANAGEMENT ADVISORS

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')¹ 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

¹ 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)². 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.

² 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.

1

Introduction

1.1 PROJECT BACKGROUND

Healthcare Management Advisors (HMA), in association with the Chronic Illness Alliance, was appointed by the *Access to Medicines Consortium*³ (the *Consortium*), to conduct research on *Consumer Access to Prescription Medicines: Identifying the Barriers*. The project was funded by the Pharmacy Guild under the Third Pharmacy Agreement.

This was the first phase of a longer term work program being undertaken by the *Consortium* to identify and quantify the impact of different barriers to accessing medicines encountered by consumers across a variety of demographic and socio-economic groups.

The timelines for the initial project were extremely tight. HMA was appointed in the week beginning 16 May 2005 and completed the project on 30 June 2005. The Expert Advisory Group (EAG) for this project comprised the *Consortium* members listed above, together with the Department of Health and Ageing and the Pharmaceutical Society of Australia.

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 feedback.** Through this 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 a research proposal.
- (4) **Final report.** A final report (this document) brings together the findings from the previous project stages.

³ The Pharmacy Guild of Australia, the Australian Medical Association (AMA), Australian Council of Social Services (ACOSS), Medicines Australia, and the Consumers' Health Forum of Australia.

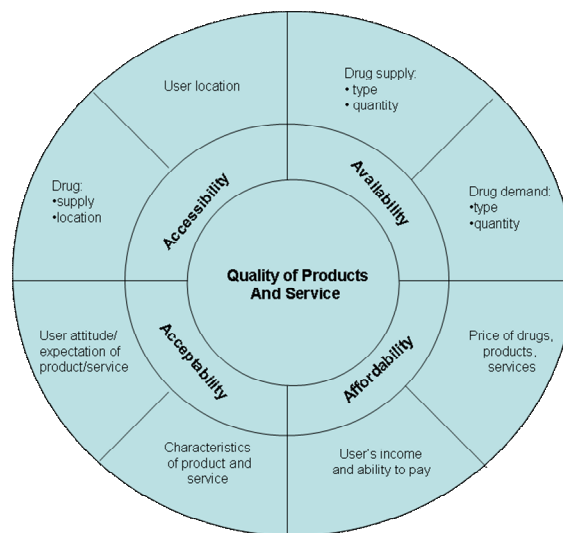
1.2 DEFINITION OF ACCESS BARRIERS

In undertaking our analysis, HMA has relied on a World Health Organisation Forum in definition of access: an *individual[s] right and ability to obtain care when needed*. Accessing medicines is affected by:

- *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*.⁴

The relationships between these dimensions are illustrated in Figure 1.1.

Figure 1.1: The Relationship between Demand and Supply Components to Medicines Access



Source: WHO, *ibid.* p.21: Adapted to an access to medicines context in Australia by HMA

The project brief listed the broad categories of consumer groups who face access barriers to prescription medicines in Australia. The conceptual relationships between these groups are illustrated in Figure 1.2.

⁴ Report of the WHO-MSH Consultative Meeting, **Defining and Measuring Access to Essential Drugs, Vaccines, and Health Commodities**, Ferney-Voltaire, France, 11–13 December 2000, Drug Management Program Management Sciences for Health, Arlington, VA 22209 USA, p.v.

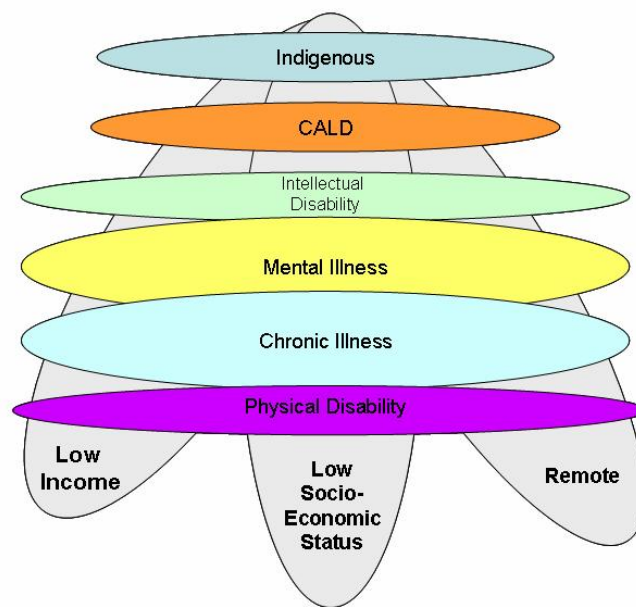
Figure 1.2: Groups with Constraints in their Access to Prescription Medicines and their Relationship

Figure 1.2 shows the complex relationships between the two types of categories that may affect access to medicines. Category one (the vertical elipses presented in grey) represents general factors that may affect anyone in the community, such as socio-economic status, income, and geographic location. People, and their associated access to medicines, may be affected by one, two or all three of these factors.

The second category of factors (the horizontal elipses) represent specific population groups such as groups from Indigenous or CALD backgrounds, or people with intellectual or physical disabilities and mental or chronic illnesses. As well as overlapping with other category two groups (such as mental and chronic illness), category two groups may or may not overlap with category one factors (one, two, three or not at all). Consistent with this, some category two groups may have a higher tendency to experience more than a single category one factors. For example, people with physical disabilities are often low income earners due to their reduced ability to work; or Indigenous people are more likely to reside in remote areas than people from an Anglo-Saxon background.

All people affected by general factors and specific groups represented in Figure 1.2 may experience constraints in their access to prescribed medicines relative to the average person in the community. Identifying and describing the nature of those constraints was the main objective of this project. We have used these conceptual frameworks to guide our analysis for the literature review and stakeholder interviews and formulate next steps in the *Consortium's* work plan.

1.3 STRUCTURE OF THIS REPORT

The remainder of this report is presented in five chapters:

- (1) Chapter 2 presents the findings of the literature review conducted for the project.
- (2) Chapter 3 describes findings from a brief examination of already existing data sources on health issues that are relevant to the project. This chapter also highlights areas where there is scope for further data specifications and data analysis.
- (3) Chapter 4 presents the key themes emerging from the telephone consultations conducted by HMA. Summaries of individual consultations, together with *preliminary pointers* for future research are at Attachment C.
- (4) Chapter 5 examines the project's findings on potential future research tasks and develops a prioritisation for future research based on a 'brainstorming' session with representatives of the EAG. That process identified four 'high priority' research tasks. Preliminary research briefs for those four tasks are presented at the end of the chapter.

2

Literature Survey

2.1 INTRODUCTION TO THE LITERATURE REVIEW

HMA conducted a detailed review of the literature which identified and discussed barriers to consumer access to medicines. This chapter discusses in detail the methodology and results of the literature search.

The barriers considered in the literature search, based on the framework described in Chapter 1, included:

- physical barriers;
- affordability;
- geographic barriers;
- acceptability to the consumer (in this category we reviewed reasons for lack of acceptability and these may relate to cultural issues, gender, socio-economic status, consumer knowledge and skills etc); and
- the quality of the products and services provided.

Not surprisingly most of the literature that we were able to source both in Australia and from overseas identified affordability as the key barrier identified by consumers, researchers and health professionals. However, we have also been able to access a number of articles, which identify and describe the other barriers listed above.

We have also examined these barriers as they relate to seven consumer groups, which were identified in the tender brief as being at risk of experiencing restricted access to pharmacy medicines. Consistent with the analytical framework presented in Chapter 1 these 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.

2.2 LITERATURE REVIEW METHODOLOGY

This section outlines the literature review methodology that has been applied. It is based on the protocol outlined in the Cochrane Reviewer's Handbook and includes the search strategy and selection criteria that were adopted for this project. Table 2.1 below presents an outline of the key components of our literature review methodology.

Table 2.1: Literature Review Methodology

Key Task	Description of Task
Determine literature review question	The formulation of clear questions to be answered or hypothesis to be tested
Search for relevant studies	Location of all relevant published and unpublished studies to limit impact of publication and other biases
Determination of studies to be included and excluded	Explicit descriptions of what types of studies are to be included to limit selection bias
Assessment of study quality	A systematic method of examining primary studies and investigation of potential biases in those studies and sources of heterogeneity between study results
Synthesising study results	Conclusions on those studies which are considered to be methodologically sound

The essential elements of our literature review methodology ensured that the:

- literature was identified according to an explicit search strategy;
- research material was selected according to defined inclusion and exclusion criteria; and
- material collected was evaluated against consistent methodological standards.

2.2.1 Search Strategy

The literature review was conducted by members of the HMA team in consultation with our specialist clinical 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. The literature search methodology incorporated the following elements:

(1) Electronic database searches

Subject and text words were used in searching databases for relevant research concerning barriers to consumer access to prescription medicines with English language limits and a publication date from 1985 to present (2005) being applied from PubMed, Informit, CINAHL, Social Sciences Index, and Wellness database and The Cochrane Library.

- (i) **Pubmed , CINAHL** The following search terms were used when searching:
Drug utilization [MESH term] OR Pharmaceutical services/supply and distribution [MESH term] OR pharmaceutical preparations [MESH major topic] OR medicines OR "drug prescriptions" OR "prescriptions, drug"[MeSH Terms] OR Prescription AND access* OR health services accessibility [MESH major

topic]) OR Health services accessibility/economics [MESH term]. Cognition disorders [MESH term] OR aged [MESH term] AND pharmaceutical preparations [MESH major topic] OR medicines OR "drug prescriptions" OR "prescriptions, drug"[MeSH Terms] OR Prescription

(ii) **Informit databases:**

(Drugs or medicines or "prescription drugs" or "prescription med*" or prescriptions or "pharmaceutical preparations") and access * and (issues or barriers or factors or NESB or CALD or migrant * or indigenous or aborigine*)

(iii) **Social Sciences Index:**

Drugs (subject heading) and access * (any field) and barriers (any field)

(iv) **Cochrane**

Nb MESH terms: Prescription drugs (ti) and access (ti) - one record only was found.

- (2) **Internet searches.** A search was made of Internet resources in Australia and internationally using search criteria such as [consumer access medicines], [consumer access drugs], [geographic access medicines], and affordability medicines].
- (3) **Scanning of reference lists.** We scanned the reference lists of publications (primary studies and reviews) found through database searches to identify further studies for consideration.
- (4) **Grey literature and conference proceedings.** There is always a risk that relevant publications may be overlooked in electronic searching due to inaccurate or incomplete indexing in the databases and weaknesses in the search strategy. Therefore, we have also contacted key consumer organisations such as Diabetes Australia, the Chronic Disease Alliance and the Community Health Foundation in order to identify and access articles that have been missed in database and reference list searches. Important results may have been published in reports, technical reports, discussion papers or other formats, which are not indexed in the major databases.
- (5) **Documenting the search.** The process of undertaking the literature review is documented in detail. The unfiltered searches were retained in their entirety for future potential reanalysis.

Selection Criteria

The search strategy involved a detailed examination of the material that had been identified as part of the search strategy. In this stage, the literature was excluded if the subject matter was insufficiently described and therefore the documentation did not contribute important information to the project. For example, longitudinal studies are likely to be a particularly valuable resource as they facilitate the testing of relationships between early events or characteristics and later outcomes, which enable the construction of theoretical models, which can then be validated in future research. In addition cross-

sectional studies, which use large samples and methodological research designs, are also valuable.

Methodological Considerations

Clearly a literature review can only report on research that has been reported. Our work suggests that there are areas relating to access to medicines on which there is little or no detailed research. The Australian literature reviewed provides no recent research, and few findings in general, about the difficulties low income people in metropolitan areas have in accessing medicines as a result of difficulties in accessing GPs, specialists or pharmacists, and as a result of financing or geographic access issues.

In undertaking the literature review, we gave consideration to a number of key issues in reviewing the research outcomes including the:

- assessment of the validity of research;
- nature of correlational research;
- measurement of influencing variables;
- consideration of differing consumer needs; and
- comparability of cross-cultural findings.

These key issues are discussed below.

Assessment of the validity of research studies

An assessment of the validity of the research studies that have been identified was undertaken using the using protocol suggested in the Cochrane Handbook⁵. This involved an assessment of each paper, which was rated according to criteria of low, moderate, or high risk of bias as outlined in Table 2.2 below.

Table 2.2: Protocol for Assessing the Validity of Studies

Risk Bias	Relationship to individual criteria	Definition
Low Risk	Plausible bias unlikely to seriously alter the results	All criteria is met
Moderate Risk	Plausible bias that raises some concerns about the results	One or more criterion partly met
High Risk	Plausible bias that seriously weakens confidence in the results	One or more criterion not met

The methodological cut-off point for inclusion of all types of studies in this review considered the overall quality of the literature retrieved and therefore a flexible approach was adopted.

- (1) **Co-relational research.** The majority of research undertaken is co-relational, and therefore cannot determine relationships between cause and effect. However this type of research is able to demonstrate significant statistical associations between factors impacting on the use of pharmacy medicines. Furthermore research studies

⁵ Cochrane Reviewer's Handbook (2002) <http://www.cochrane.dk/cochrane/handbook/hbook.htm>

are likely to demonstrate the relationship of various factors on consumer access to medicines.

- (2) **Measurement of influencing variables.** The literature review has sought to collect information regarding consumer feedback in order to identify the issues that have impacted upon consumer accessibility to pharmacy medicines.
- (3) **Comparability of cross-cultural findings.** The review considered and summarised relevant literature from both the Australian and international contexts. However, as Australia has a unique system of medicine supplies through the PBS, much of the international literature does not provide information that is directly comparable.

2.3 FINDINGS

2.3.1 *Physical Barriers to Accessing Medicines*

Physical barriers to accessing medicines can include a lack of pharmacy services within a particular location (eg within 5 kilometres of the consumer's residence) but could also be related to the ability of the consumer to travel to the pharmacy (eg due to a lack of public transport). In addition particularly for older or cognitively impaired people, the closure of their local pharmacy may cause them to change or cease the use of their medications, as they may not have the ability to access an alternative service.

A study of over 4,000 consumers, conducted by Xiao et al ⁶ in Iowa, USA found that the closure of local pharmacies resulted in a decrease in consumers' prescription drug use.

On the other hand, the provision of pharmacy services in association with a medical practice (especially in a community health centre) has been found to improve consumer access to pharmaceuticals and also to improve therapeutic outcomes through complementing the clinical activities of the other health care providers in the service.^{7 8}

In Australia, Aboriginal people are often unable to access pharmacy services appropriately. Richard Murray⁹ has written that the failure of Aboriginal people to access medicines is consistent across urban, rural and remote areas. He lists the non-geographical barriers as being "poverty, administrative matters (such as entitlement issues) and attitudes and behaviours of service providers".

⁶ Xiao H, Sorofan B, Manasse HR Jr *The analysis between pharmacy closures and prescription drug use: a retrospective analysis of Medicaid prescription claims in Iowa* American Journal of Managed Care 2000 March 6(3): 366-72

⁷ Dent LA, Stratton TP, Cochran GA *Establishing an on site pharmacy in a community health centre to help indigent patients access medications and to improve care* Journal Pharmacy Association (Washington) 2002 May-June: 42(3) 497-507

⁸ Wells et al *Using pharmacies in Washington state to expand access to emergency contraception* Family Planning Perspectives 1998 Nov-Dec; 30 (6): 288-90

⁹ Murray R., *Prescribing issues for Aboriginal people* Aust Prescriber 2003; 26:106

Keys Young ¹⁰ found that poor transport could be a barrier to access for Aboriginal people living in urban areas and that “many patients will not walk to the chemist if it is more than a few blocks away.”

In 2000, the Commonwealth established new arrangements for the supply of medicines to remote area Aboriginal Health Services. This occurred because statistical evidence from the PBS showed that access to medications by remote area Aboriginal people was significantly lower than for other members of the community - despite their health status clearly being worse than the rest of the Australian population.

Although the evaluation of the program demonstrated a significant increase in medication utilisation by people in these communities, it also identified a range of access barriers that still required attention. The evaluation team found that:

- problems getting required medicine were relatively common due to limitations to stock at pharmacies, limitations on imprest lists and unanticipated demand;
- some services had difficulty managing the bulk supply of drugs due to lack of skilled staff;
- non PBS medicines were not included in the scheme – so sometimes PBS medicines were prescribed inappropriately when an over the counter remedy would have sufficed;
- schedule 8 medicines were not included. This limited access to appropriate pain relief for some patients requiring palliative care; and
- some of the geographic limits to the scheme were not reasonable as some communities were not deemed to be remote yet they were still up to 35km away from the nearest pharmacy.¹¹

Worse health status also appears to be a consistent predictor of less consumer access to medications. It appears that consumers will more readily access medications consistently for an acute condition - but those suffering from chronic and debilitating conditions are less likely to consistently access appropriate medications.¹² The reasons for this are unclear in the literature.

Newby et al ¹³ found that about 10% of the people in their study of 786 Australians believed that they did not have access to adequate information about the medicines that they were taking. This was due to either their own geographical isolation or in some cases because their information source (health professional) was perceived to be unavailable to them.

¹⁰ Keys Young, *Market Research into Aboriginal and Torres Strait Islander Access to Medicare and the Pharmaceutical Benefits Scheme*, November 1997.

¹¹ Menzies School of Health Research University of Melbourne *Research Project: Evaluation of the Supply of Pharmaceuticals to Remote Area Aboriginal Health Services* 2004

¹² Saver BG, Doescher MP, Jackson JE, Fishman P. *Seniors with chronic health conditions and prescription drugs: benefits, wealth, and health*. Value Health. 2004 Mar-Apr; 7 (2): 133-43.

¹³ Newby et al *Consumer needs for medication information: a role for Cochrane?* 6th Annual Cochrane Colloquium Abstracts, October 1998 in Baltimore

2.3.2 *Affordability of Medications*

Due to the relative inexpensiveness of prescription medicine in Australia, the effect of costs of drugs on consumer behaviour in other countries (especially USA) cannot be completely extrapolated to the Australian experience. However, there can be no doubt from the proliferation of literature on the topic that cost is the most significant factor in predicting consumer behaviour in relation to the use of medications.

Shulman who writes that millions of low-income workers in the US fail to obtain their prescription drugs for hypertension makes a salient point. Shulman points out that rates of hypertension are inversely related to income, meaning that those least able to afford medications are most likely to suffer complications thus compounding the problem for those unable to afford medications¹⁴.

The studies summarised below indicate that the cost of drugs is a significant behaviour-modifying factor across a range of nationalities and population groups.

Schafheutle et al¹⁵ found that the cost of medication influenced the illness management behaviour of their study group in North-west England. Participants in the study, who had difficulty paying for prescriptions, utilised a number of strategies to reduce the costs. For example, they had only some of the prescribed items dispensed, took smaller doses or substituted with an over the counter product.

An Israeli study of children from low-income households prescribed antibiotics for acute infection also found that cost was a significant barrier to the purchase of the prescribed medication¹⁶.

An Australian study conducted in the Newcastle/Hunter region found that as many as 25% of the 420 households surveyed modified their behaviour due to the costs of medications. This included delaying their visit to the GP, not buying all of their prescription medicines or not refilling prescriptions¹⁷.

People with disabilities have also been identified as being at risk of non compliance with prescribed medication therapies due to cost factors, and that their health problems are exacerbated as a result. Kennedy and Erb¹⁸ found that more than half of 1.3 million adults with disabilities surveyed in the National Health Interview Surveys (USA) suffered health problems due to poor compliance. "Severe disability, poor health, low income ... and a high number of prescriptions," increased the likelihood of the consumer being non compliant.

¹⁴ Shulman N *Economic issues relating to access to medications* Cardiovascular Clinic 1991; 21 (3): 75-82

¹⁵ Schafheutle et al *Access to medicines cost as an influence on the views and behaviour of patients* School of Pharmacy and Pharmaceutical Sciences University of Manchester, UK

¹⁶ Reuveni et al *The effect of drug co-payment policy on the purchase of prescription drugs for children with infections in the community* Health Policy 2002 Oct 62 (1): 1-13

¹⁷ Doran E et al *Patient co-payments and use of prescription medicines* Australian New Zealand Journal of Public health 2004 Feb. (1) 62-7

¹⁸ Kennedy J. Erb C *Prescription non-compliance due to cost among adults with disabilities in the United States*. American Journal of Pubic Health 2002 Jul; 92(7): 1120-4

The international literature provides significant evidence that cost is a significant barrier for older people in accessing medicines (especially for those on lower incomes and those with chronic conditions)^{19 20}.

In Australia, The Consumers' Health Forum of Australia (CHFA)^{21 22} has demonstrated that while the PBS provides access to medications at an affordable price for most consumers, those people who have a chronic condition do not have their needs effectively met, particularly if they are on a low income and are not concession cardholders.

While the PBS Safety Net protects such people to some extent, there are logistical issues which still impact on their ability to pay for medicines. For example, if before they reach the safety net they need to purchase a number of prescriptions all in one week because they have used up all of their medications, if they suffer an acute illness episode or if an additional family member suffers an acute illness, they may find that they have inadequate financial resources to meet the costs of their drugs.

As in the study by Doran cited above, CHFA found that consumers implemented a number of strategies in order to overcome the cost burden and this in turn reduced the quality of their medication use. Strategies identified include not purchasing or using some drugs, reducing their dosage of prescribed medications, visiting a hospital outpatient department for acute conditions in order to get access to free drugs, sharing prescriptions among family members or prioritising which family members could use the prescribed medications.

2.3.3 Geographic Barriers

In Australia, remote communities (particularly Aboriginal communities) have recognised difficulties in accessing medicine appropriately. Keys Young²³ found that Aboriginal people living in both remote and rural areas could encounter barriers to access of medicines because of distance from a pharmacy, lack of public transport options and lack of access to private transport options.

In addition, the distances involved in dispensing medications to patients in remote communities can lead to the patient not receiving the medication in a timely manner. For example, some Aboriginal communities have a weekly 'drop-off' of medication and collection of scripts, or in other cases medications are delivered by post. These systems

¹⁹ Xu K *Financial disparities in prescription drug use between elderly and non elderly Americans* Health Affairs (Millwood) 2003 Sept-Oct; 22(9): 210-21

²⁰ Saver BG, Doescher MP, Jackson JE, Fishman P. *Seniors with chronic health conditions and prescription drugs: benefits, wealth, and health*. Value Health. 2004 Mar-Apr; 7(2): 133-43

²¹ The Consumers' Health Forum of Australia *Cost of Chronic Illness and Quality Use of Medicine*, April 1997

²² The Consumers' Health Forum of Australia *The Pharmaceutical benefits Scheme and People with Chronic Condition*, March 1999.

²³ Keys Young, *Market Research into Aboriginal and Torres Strait Islander Access to Medicare and the Pharmaceutical Benefits Scheme*, November 1997.

result in patients (particularly those with an acute illness) not receiving their medications within an appropriate timeframe.

The remoteness of the pharmacist from the patient also means that these people do not receive personal advice and counselling about the use of their medicines from the dispensing pharmacist.

The problem of viability of pharmacies and therefore closures in rural areas was highlighted in two articles originating from the USA^{24 25}. While no Australian research was found about this issue, it would seem likely that the same problems would exist here.

Both of the articles cited, indicated that policy changes relating to medication supply, decreasing financial viability and lack of workforce supply were leading to pharmacy closures in rural areas of the USA and that this in turn would lead to reduced access to medications, especially for the elderly.

2.3.4 Acceptability

The acceptability indicators chosen by the project team include “percentage of patients who have not purchased a prescribed drug for financial or non financial reasons”.

A 1996 survey conducted by Hanlon²⁶ et al in North Carolina USA concluded that “drug use patterns by community dwelling elderly people differ with cognitive status”, and that their subjects (who were aged >65 years) with impaired cognitive status were less likely to use either prescription or non prescription medications than cognitively intact people. The group did not draw any conclusions as to the reasons for this.

Language difficulties have also been demonstrated to be a barrier to accessing appropriate medications where the patient does not speak the dominant language. Researchers in both English speaking and non-English speaking countries have concluded that these persist despite the provision of interpreters and information written in other languages. Written information may not be understood because the patient may have poor literacy in their own language or because the information is not culturally appropriate for them. Difficulties also arise because cultural differences may lead to different beliefs about health and illness and the use of medications^{27 28}.

²⁴ Xiao H, Sorofan B, Manasse HR Jr *The analysis between pharmacy closures and prescription drug use: a retrospective analysis of Medicaid prescription claims in Iowa* American Journal of Managed Care 2000 March 6(3): 366-72

²⁵ Casey MM, Klingner J, Moscovice I *Pharmacy services in rural areas: is the problem geographic access or financial access?* Journal Rural Health 2002 Summer 18 (3): 467-77

²⁶ Hanlon et al, *Is medication use by community dwelling people influenced by cognitive function?* Age and Ageing 1996 May; 25(3): 190-6

²⁷ Westberg SM, Sorensen TD *Pharmacy related health disparities experienced by non-english-speaking patient: Impact of pharmaceutical care.* Journal of Pharmacy association (Washington DC) 2005 Jan_Feb; 45 (1): 48-54

²⁸ Schaafsma ES, Raynor TD, de Jong -van den Berg LT *Accessing medications by ethnic minorities: barriers and possible solutions* Pharmacy World Science 2003 Oct, 25(5): 185-90

In Australia, Aboriginal people are at high risk of not being able to access medication appropriately. The issues may be similar to those for people of other ethnic backgrounds in that there are language barriers, literacy barriers and also cultural and spiritual beliefs about health and illness, which are different to that of the mainstream.

In some cases people do not receive appropriate information about medicines as is highlighted in the quotation below.

*'Our services are tired of seeing patients go without medicines and get really ill because they physically can't get to a chemist shop, or because they can't afford their medicines. They're also tired of seeing patients come back sicker because they didn't have the **right people on hand to explain properly to them how to use the medicines**, and so they didn't take them or they made mistakes with them.'*

*The late Dr Puggy Hunter, October 2000*²⁹

2.3.5 *Quality Issues*

The literature commenting on the quality of medication supply both in Australia and overseas indicates that geographical remoteness of dispensaries leads to poorer quality dispensing and this may be due in some part to the fact that medications are being dispensed by non pharmacists. For instance, in Queensland where rural and remote nurses provide a dispensing service through the local public hospitals, a survey of nurses demonstrated that they believed they required more support and improved guidelines in order to provide a quality service³⁰.

Murray³¹ makes the point that clinical practice in Aboriginal communities (both remote and urban) is different than practice in the mainstream and that it is necessary for prescribers to have a high level of technical proficiency in managing Aboriginal health issues in order to ensure that Aboriginal people get the most appropriate access to the medications that they need. This has not always been the case.

The program evaluation of the Supply of Pharmaceuticals to Remote Aboriginal Health Services³² found a number of physical access barriers as cited above but they also identified some quality issues - particularly in the area of training and retaining appropriate dispensing staff and maintaining and improving the involvement of doctors in the program.

²⁹ R Murray *Prescribing issues for Aboriginal people* Australian Prescriber 2003; 26:106-9

³⁰ Fiore S et al *Support needs of supply nurses in rural and remote Queensland* Australian Journal of Rural Health 2005 Feb; 13 (1); 10-3

³¹ R Murray *Prescribing issues for Aboriginal people* Australian Prescriber 2003; 26:106-9

³² Menzies School of Health Research University of Melbourne *Research Project: Evaluation of the Supply of Pharmaceuticals to Remote Area Aboriginal Health Services* 2004

2.4 CONCLUSIONS

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 availability³³ 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.

Analysis of Routinely Collected Data

3.1 BACKGROUND

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* around barriers to consumers accessing medicines.

3.1.1 Approach to the data analysis

HMA obtained the National Health Survey, SDAC and HES publications from the Australian Bureau of Statistics website³⁴. Relevant data and tables were extracted from these publications and are summarised below.

Information on preventable hospital admissions represented by geographical location and socio-economic status from the National Morbidity Data was obtained by HMA from the Australian Institute of Health and Welfare (AIHW) from the Australian Council of Social Service (ACOSS) via the ACOSS EAG representative Associate Professor Roy Harvey. These data were statistically analysed for significant differences by *TRC Mathematical Modelling (TRCMM)*, based at the University of Adelaide. The results of this analysis are discussed below.

In depth discussion on the data from the National Health Survey, Disability, Ageing and Carers Survey, Household Expenditure Survey and National Morbidity Data, is provided at Attachment A.

As part of these published data reviews performed by HMA, a review of drug related preventable hospital admissions is also discussed below.

3.2 NATIONAL HEALTH SURVEY

The Australian Bureau of Statistics (ABS) compiles a National Health Survey approximately every four years. The latest survey published was conducted in 2001, and published as several separate reports including an overview report (summary, 2001), Aboriginal and Torres Strait Islander results (2001), Mental Health (2001) and Use of Medications (1995).

The National Health Survey Summary includes demographic information such as country of birth, language spoken at home, education level, employment, region of habitation,

³⁴ <http://www.abs.gov.au>

income and socio-economic disadvantage, as well as health information such as long-term illness, medical treatments sought, type of medication used, dietary habits and weight. These data are, in general, analysed by age and sex, and occasionally demographic indicators.

3.2.1 *Types of treatments*

The data from the National Health Survey Summary on types of treatment sought (e.g. hospital inpatient, emergency or outpatient, or consultation with a doctor) indicated that people with low incomes, of socio-economic disadvantage or non-employed were generally more likely to seek medical treatment of some sort than the total population. Demographic status such as education or cultural background did not substantially affect the type of treatment sought. Similarly, regional location did not affect the type of treatment sought, although people in major cities were less likely to be admitted to hospital (inpatient) than people from regional or rural areas.

3.2.2 *Use of Medication*

The 1995 use of medication survey collected information on types of medications used for illnesses classified as a 'National Health Priority'. The report showed that 59.1% of the population reported using medications of some sort (not including vitamins and herbal products). The majority of medications used were pain relievers (23.6% of population), medications for heart problems (10.6% of population) and skin ointments (9.8%). For medications for other chronic illnesses, 6.1% of the population used asthma medication, 2.6% used arthritis medication and 1.1% used medication for diabetes.

Comparison of the data by socio-demographic status showed that several socio-demographic indicators may influence medication usage, perhaps highlighting areas for investigation of barriers to medication access. Most notably there were differences in medication use depending on a persons' country of origin, but whether these variations were due to varying rates of specific diseases/illness in people from different countries of origin, or are due to actual barriers to medicine access was not apparent from the published data.

With regards to prescribed medications, there were variations in the proportion of people using medication with or without advice (or prescription) which seemed to be largely dependent on the type of medication (e.g. opioid versus aspirin).

3.2.3 *Chronic Illness*

Long term conditions (or chronic illnesses) were defined in the National Health Survey (2001) as a condition which was current at the time of the survey and which, in the respondent's opinion, had lasted for six months or more, or which he or she expected would last for six months or more.

Two of the most common chronic illnesses were asthma (11.6% of the population) and diabetes (or high blood sugar levels, 3.3% of the population). Analysis of chronic or long term illness indicated that there may be variations in chronic illness incidence depending on a persons' socio-demographic status. Examples of this were higher rates of

disease/illness among non-employed people than employed or unemployed people (cause or effect was not established) and people with lower incomes (1st quintile) reported higher rates of arthritis and disease of the eye and adnexa than people with high incomes (5th quintile).

3.2.4 *Mental Health*

The long-term mental and behavioural problems included in the 2001 National Health Survey included information on alcohol and drug problems, mood (affective) disorders, anxiety related problems, problems of psychological development, behavioural and emotional problems. Psychological distress was defined from the Kessler Psychological Distress Scale 10 items (K10).

Approximately 1.8 million people (9.6% of the total population) reported having (or had) long term mental or behavioural problems in 2001. These were most likely to have been anxiety or mood related problems (4.5% each). The report indicated higher rates of mental and behavioural problems or very-high psychological distress among unemployed or non-employed people, people without post-school qualifications and people from disadvantaged socio-economic areas.

People with mental or behavioural problems were 1.5 times more likely to visit a hospital or consult a doctor or other health professional than people without mental or behavioural problems; and people with very high psychological distress were 2 times or more likely to visit a hospital or consult a doctor or other health professional than the national population. Consistently, people with mental or behavioural or psychological problems use substantially higher amounts of mental health medications, but surprisingly, almost half of the population with mental or behavioural problems or psychological did not use any medication. People with mental and behavioural problems or psychological distress also showed higher prevalence rates in some medication use.

3.2.5 *Indigenous Background*

In the National Health Survey (2001), *people of indigenous background* refers to people who identified themselves, or were identified by another household member, as being of Aboriginal and/or Torres Strait Islander origin.

The indigenous population was considerably younger than the non-indigenous population (majority of indigenous population in the 5-14 years age group compared to the majority of the non-indigenous population in the 55 plus age group), therefore the results have been “age-adjusted” for comparison to national data.

Analysis of the data collected for indigenous Australians indicated that one third of indigenous Australians reported their general health as ‘fair or poor’, almost twice the rate of non-indigenous Australians (34% compared with 18%, respectively, see Attachment A: Table A.11). However, both Indigenous and non-Indigenous Australians were equally likely to report having at least one long term health condition (78% each).

Analysis of the report indicated that the major long-term health conditions of indigenous Australians were eye sight problems, circulatory problems and asthma. Indigenous Australians living in non-remote areas were more likely to report having long term health conditions. Comparison of indigenous to non-indigenous Australians with regards to health actions taken indicated that indigenous Australians were twice as likely to have visited hospital (inpatient, outpatient or emergency) and more likely to see a nurse or Aboriginal Health worker than non-indigenous Australians. There was no significant difference between consultations with doctors or chemists between indigenous and non-Indigenous Australians (despite their generally worse health status), but indigenous Australians living in remote areas were less likely than non-indigenous Australians living in non-remote areas to see a chemist (0% compared with 5%, respectively).

3.2.6 *Conclusions from the 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')³⁵ 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 hospitals, outpatient clinics and doctor visits) and less use of preventative and dental services.

The EAG emphasised that the scope of the current study was to examine existing statistical material and not to conduct primary research. At the conclusion of this study, the following aspects of the data for this survey could be further examined. Additional,

³⁵ Mathers, C. Enough to make you sick: how income and environment affect health. Research paper No. 1, National Health Strategy, 1992.

unpublished information could be obtained from the ABS as a fee for service product. Tables analysing the following information:

- type of medical contact in last 2 weeks (chemist, general practitioner, other health professional, total) by National Health Priority Area (e.g. Asthma, Diabetes, Injury (as long-term condition), cardiovascular, disease, cancer, mental health problem, Arthritis and other musculoskeletal disorders);
- type of medical contact in last 2 weeks (chemist, general practitioner, other health professional, total) by income level;
- type of medical contact in last 2 weeks (chemist, general practitioner, other health professional, total) by Kessler Psychological Distress Scale 10 (grouped); and
- type of medical contact in last 2 weeks (chemist, general practitioner, other health professional, total) by country of birth.

It is also possible to discuss design of the next National Health Survey by contacting the ABS directly.

3.3 DISABILITY, AGEING AND CARERS SURVEY

The *Survey of Disability, Ageing and Carers* (SDAC, ABS 2003) defined disability as any limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities.

The SDAC 2003 reported one in five people in Australia (3,958,300 or 20.0%) had a reported disability. This rate was much the same for males (19.8%) and females (20.1%).

The disability rate increased with age reaching 92% for those aged 90 years and over. The prevalence of profound or severe core-activity limitation gradually increased from 3% for age groups 0-4 years through to 10% for 65-69 years and then increased sharply to 74% for those aged 90 years and over. This contrasted with the overall disability rate which increased steadily from 4% of 0-4 year olds to 41% of 65-69 year olds and 92% of those aged 90 years and over. Taking this into account, the following data from the SDAC report (2003) is for persons aged 15-64 years only.

Analysis of reported disabilities and/or core-activity limitations indicated that there is an inverse correlation between education/employment and disability. The majority of disabled people are in low income quintiles with a median gross weekly income of approximately half that of non-disabled people (\$255 compared with \$501, respectively). There was no difference in geographic location of disabled and non-disabled people with the majority of both living in major cities.

3.3.1 Conclusions from the 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.

At the conclusion of this study, other useful information not published in SDAC (2003) that could be obtained would include data about the use of medication or types of treatments sought for people with disabilities.

3.4 HOUSEHOLD EXPENDITURE SURVEY (HES)

3.4.1 Background to the Dataset

The 1998–99 *Household Expenditure Survey* (HES) collected detailed information about the expenditure, income and household characteristics of a sample of 6,893 households resident in private dwellings throughout Australia. HES results have been used for many applications including updating the weighting pattern of the Consumer Price Index, conducting standard of living studies, evaluating government policy and market research.

Analysis of HES data showed that on average, Australians spend 4.6% of their weekly goods and services expenditure on medical care and health expenses, compared to 13.9% for housing costs, 18.2% for food, 16.9% for transport and 12.7% for recreation. Unemployed people spent much less (proportionally) on medical and health expenses than employed or non-employed people and couples without children spent less on medical and health expenses than couples with children (1, 2 or 3 or more). Of families with children, couples with two children spent more than couples with one child on medical expenses. Couples with three or more children, however, spent less on medical and health care expenses, and more on food expenses.

Country of origin also highlighted differences in household expenditure with people who originated in Italy or Vietnam spending proportionally less on medical and health care expenditure than people originating from other countries and people originating from the Netherlands spending 1.5 times the national total on medical and health care expenses.

3.4.2 Conclusions from the 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..

At the conclusion of this study, the following points could be looked into further:

- details of practitioners fees and expenditure on medical and pharmaceutical products by country of origin;

- details of practitioners fees and expenditure on medical and pharmaceutical products by employment status;
- details of practitioners fees and expenditure on medical and pharmaceutical products by geographical location; and
- details of practitioners fees and expenditure on medical and pharmaceutical products by number of dependent children.

3.5 HOSPITAL MORBIDITY DATA

3.5.1 Background to the Dataset

In 1993, the Australian Health Ministers' Advisory Council (AHMAC) commenced annual publications of a subset of *State hospital morbidity data* grouped to Australian National Diagnosis Related Groups (AN-DRGs) which include costing information, known as the *Australian Casemix Report on Hospital Activity*. This information can be obtained from the Australian Institute of Health and Welfare (AIHW).

Using this information, the AIHW has previously published a report on the health status of population groups by regional area (*Rural, Regional and Remote Health: Indicators of Health*, AIHW, 2005). This report analysed data from sources including the ABS Census of Population and Housing, national surveys such as the *National Health Survey*, the *Survey of Mental Health and Wellbeing of Adults*, the *National Nutrition Survey*, *Child Dental Health Survey*, administrative data sets such as Medicare, Pharmaceutical Benefits Scheme, Hospital Morbidity and Hospital Establishments data, and ABS Mortality data set. The data were analysed by regional location (e.g. Major City, Inner Regional, Outer Regional, Remote and Very Remote areas, as defined by the ABS Australian Standard Geographical Classification (ASGC) Remoteness Areas), sex and age.

The report indicated that overall there was no significant difference in chronic illness or mental health across regional settings, that people in regional areas were more likely to have a disability than in major cities (1.3 times greater for men and 1.05 times greater for women), that life expectancies were highest in major cities and lowest in very remote areas, and the leading causes of the higher death rates experienced in regional and remote areas were mainly circulatory diseases (42% of the 'excess' deaths) and injury (24% of the 'excess' deaths), with respiratory disease and cancers contributing about 10% of the 'excess' each.

Expanding on these previous data, the *Access to Medicines Consortium* asked for further analyses of the hospital morbidity data with respect to socio-economic status as well as regional area for all potentially preventable hospital separations. The data was extracted by the AIHW and sent to HMA via Assoc. Prof. Roy Harvey, representing Australian Council of Social Service (ACOSS). For each *Potentially Preventable Hospital Admission* (PPH) or *Diagnosis Related Group* (DRG), this data was represented by regional area and one other variable, the *Socio-Economic Index for Area* (SEIFA) variable index as follows:

- (1) **Relative socio-economic disadvantage.** Classifies areas by degrees of disadvantage, eg. a low score represents areas of low income, low education, high unemployment and jobs in relatively unskilled occupations. It is important to note that a high score represents areas of low disadvantage and not areas of high advantage (SEIFA, Australian Bureau of Statistics (ABS), 2001);
- (2) **Relative socio-economic advantage/disadvantage.** Classifies areas by degrees of advantage and disadvantage eg. a low score represents areas with a high proportion of low income earners, more employees in relatively unskilled occupations and a low proportion of people with high incomes or in skilled professions (SEIFA, ABS, 2001);
- (3) **Economic resources.** Reflects only the income and expenditure of families in an area, eg. a low score represents areas with a high proportion of low income earners and families living in small dwellings, with few high income earners (SEIFA, ABS, 2001); and
- (4) **Education and occupation.** Reflects the education (level achieved or continuing) and the occupation (or unemployment) of area eg. a low score represents areas with high proportions of people with low educational attainment, employed in unskilled occupations or unemployed (SEIFA, ABS, 2001).

For the purposes of this report only the data for regional area by relative *socio-economical advantage/disadvantage* was analysed for statistically significant variation across the defined potentially preventable hospital admission DRGs. This analysis was performed by TRCMM located within the Statistics Department of Adelaide University, assuming a Poisson distribution. A Poisson distribution is defined as “a simple form of random occurrence” and applies to various events of discrete nature whenever the probability of the event happening is constant in time and space (i.e. the probability of an event happening is independent of the surrounding events).

HMA provided TRCMM with the AIHW data supplied by ACOSS. This data included ‘standard rates’ that were computed for various medical conditions, broken down by socio-economic and regional categories (as described above). TRCMM was informed that the standard rates were averages of “scores” assigned to each person in each socio-economic/regional category pair³⁶. The number of data included in the calculation of the standard rates was also provided to TRCMM, but not the original (raw) data itself.

HMA instructed TRCMM to assume that the populations within each socio-economic group/region pair are Poisson distributed³⁷ with regard to the scores assigned to each person.

HMA asked TRCMM to determine if there is any significant difference between the standard rates computed within the datasets corresponding to certain health issues, or PPH Categories, and whether the sample sizes are large enough for meaningful statistical analysis.

³⁶ Recommended approach advised by Ian Titulear, Hospital Statistical Expert, AIHW.

³⁷ Recommended approach advised by Ian Titulear, Hospital Statistical Expert, AIHW.

3.5.2 Analysis of Results

The analysis performed was to determine whether the standard rates for each socio-economic group/region pair are significantly different.

The null model investigated was that *“the SEIFA deciles and remoteness categories are not significant in determining the average standard rates.”*

To investigate the null hypothesis TRCMM looked at a generalised log-linear model. This model applied a Poisson log-linear model to the observed cell totals with an offset term included to allow for the different number of scores in each cell.

The null deviance of the fitted model was an indication of how far the fitted model was away from the null model. If this deviance is relatively high then the null hypothesis should be rejected since the model using the decile and category data has achieved a much better result than if these were not present.

The p-value is a measure of the level at which we should reject the null hypothesis, so that a p-value of 0.05 indicates that the null hypothesis should be rejected at the 95% level.

The results of the analysis are summarised in Table 3.1 below. For each category, the null deviance, degrees of freedom and the results of the test of the null hypothesis are shown. These results showed that the only category for which the null hypothesis could not be rejected was for the “nutritional deficiencies” category. For all of the other categories the p-value was 0.0 and hence the null hypothesis was rejected.

This indicates that for all of these PPH categories there was enough significant variation between cells to indicate that SEIFA deciles and ASGC remoteness categories are important in determining the standard rates.

Table 3.1: Statistical analysis of PPH category (DRG) by remoteness.

PPH Category	Null Deviance	Degrees of Freedom	P - value
Ear nose and throat infections	90034.06	38	0
All separations - not PPHs	761657914	38	0
Angina	102232.4	38	0
Appendicitis	21736.54	38	0
Asthma	59713.3	38	0
Cellulitis	50993.48	38	0
Chronic obstructive pulmonary disease	219789.9	38	0
Congestive cardiac failure	60260.67	38	0
Convulsions and epilepsy	90303.47	38	0
Dehydration and gastroenteritis	94550.4	38	0
Dental conditions	162774.8	38	0
Diabetes complications	5404867	38	0
Gangrene	2264.69	37	0
Hypertension	14399.11	36	0
Influenza and pneumonia	16185.76	38	0
Iron deficiency anaemia	18103.05	38	0
Nutritional deficiencies	25.80456	27	0.529466
Other vaccine-preventable conditions	3785.348	37	0
Pelvic inflammatory disease	3874.382	38	0
Perforated/bleeding ulcer	1294.571	38	0
Pyelonephritis	53074.83	38	0
Total acute conditions	1897448	38	0
Total chronic conditions	8324854	38	0
Total selected potentially preventable hospitalisations	14807344	38	0
Total vaccine-preventable conditions	20698.8	38	0

3.5.3 Conclusions about the Hospital Morbidity Data

The statistical analysis indicated that for all but one of the PPH categories there was enough variation between data cells to indicate the cell's SEIFA decile and ASGC remoteness categories were significant (for full report see Appendix A)³⁸. 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.

³⁸ Analysis performed by TRC Mathematical Modeling.

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.

3.6 DRUG RELATED PREVENTABLE HOSPITAL ADMISSIONS

The drive for investigation of possible barriers to consumer access to medications comes, in part, from the number of preventable hospital admissions due to misuse of medications.

A review of the extent of drug related hospitalisation in Australia (considering information from the *Australian National Hospital Morbidity Collection*, the *Quality in Australian Health Care Study* and various studies assessing drug related hospital admissions) indicated that there were over 20,000 drug related hospital admission (assessed as separations) in 1992-93³⁹. These occurred predominantly in population groups over 55 years of age, with slightly higher rates in females. However, the data was not standardised against the drug utilisation rate of these data sets.

The Roughead (1999) review indicated that the drugs most associated with hospital admissions were *anti-neoplastic and immuno suppressive drugs, penicillins and antibiotics, hypertensive agents, corticosteroids, anticoagulants, cardioglycosides, antirheumatic drugs, cytotoxins, non-steroid anti-inflammatory drugs and central nervous system depressant*. Of these drug related hospital admissions, it was reported that 32%-69% could have been prevented, which, by extending these data to the national level, translates to an estimated cost of approximately \$350 million annually.

Assoc. Prof. Elizabeth Roughead has also contributed to more recent papers on hospital admissions, notably the *Second National Report on Patient Safety; Improving Medication Safety, 2002*⁴⁰. This paper confirms that of all hospital re-admissions, 2-3% were due to medication related problems, and most were preventable. Similar to the 1999 review⁴¹, the patient safety report indicates that the medications involved in adverse drug reactions are usually *chemotherapy drugs, anti-inflammatories, drugs for heart disease and high blood pressure, anticoagulants, antibiotics, medicines for the central nervous system and corticosteroids*.

Proposed methods to reduce the medication incidence include increased education for the patient, increased communication between the hospital and community sector with regards to a patient's medication regime and changes to that regime and computerised

³⁹ Roughead, E. The nature and extent of drug related hospitalisations in Australia. J. Qual. Clin. Practice, **19**: 19-22, 1999.

⁴⁰ Australian Council for Safety and Quality in Health Care. Second National Report on Patient Safety; Improving Medication Safety, July 2002.

⁴¹ Roughead, E. The nature and extent of drug related hospitalisations in Australia. J. Qual. Clin. Practice, **19**: 19-22, 1999.

adverse drug alerts to automatically signal a possible adverse drug event when medication is prescribed⁴².

⁴² Australian Council for Safety and Quality in Health Care. *Second National Report on Patient Safety; Improving Medication Safety*, July 2002.

Telephone Consultations: Themes that Emerged

4.1 BACKGROUND

HMA conducted telephone interviews with the key stakeholders identified by the EAG in the project planning phase. This chapter of the report describes the process that was undertaken and the themes that emerged from these consultations.

4.1.1 *The Consultation Approach*

HMA forwarded, via email, a one and a half page overview of the project to a senior person within the organisation (often the CEO) in the week beginning 16 May 2005. This initial contact was followed-up by a telephone call checking that the email had been received and seeking to schedule a time for the telephone consultation. Once a time had been scheduled, HMA then emailed an interview template to the nominated contact that described the information that we were seeking to obtain through the telephone consultation. A copy of that document is at Attachment B. Although this document is quite structured, in practice the interviews were much more informal and broad ranging, depending on each respondents' level of knowledge of access to medicines issues and the themes that emerged throughout the interview.

A list of the organisations approached for consultation is provided in Table 4.1. From this, it can be seen HMA made contact with an interest group(s) in all major thematic areas.

4.1.2 *Interview summaries*

HMA has prepared a summary of each of the interviews conducted. In most cases the interview record has been categorised under the main access to medicines barrier themes: accessibility, affordability, availability and acceptability. Where possible we have sought to identify *further pointers for research* that HMA identified as a result of the interviews.

The summaries for interviews conducted are presented in Attachment C.

The remainder of this chapter describes the themes that have emerged from discussions held. For each access barrier theme we have sought to identify:

- issues that are common to all groups that we have consulted;
- issues that are common to several groups, but not all; and
- issues specific to individual stakeholders.

Table 4.1: Key Stakeholder Organisations Consulted via Telephone

Organisation
<i>Overarching Perspective</i>
Consumer Health Forum
<i>People with a Chronic Illness</i>
Diabetes Australia
Arthritis Foundation of Victoria
Epilepsy Australia
National Asthma Council Australia
<i>People with a Mental Illness</i>
Schizophrenia Australia Foundation /SANE
Australian Mental Health Consumer Network (AFDO Member)
<i>People from Culturally and Linguistically Diverse (CALD) backgrounds</i>
Federation of Ethnic Communities' Councils of Australia (FECCA)
National Prescribing Service (NPS) – as a result of a specific consultancy project with FECCA
Action on Disability within Ethnic Communities (ADEC)
<i>People with a Disability</i>
National Council on Intellectual Disability. (AFDO Member)
Physical Disability Council of Australia (AFDO Member)
<i>Indigenous people</i>
Dr Richard Murray – Key informant
<i>People living in rural and remote areas</i>
National Rural Health Alliance (NRHA)
Council of Remote Area Nurses of Australia CRANA (NRHA Member)
Health Consumers of Rural and Remote Australia (HCRRRA) (NRHA Member)
<i>People on low incomes</i>
Australian Federation of Homelessness Organisations (ADHO)

4.2 AFFORDABILITY ACCESS ISSUES

4.2.1 *Issues common to all groups*

Issues common to all groups around affordability barriers to accessing prescription medicine raised during the consultations were:

- (1) **Listing on the schedule of pharmaceutical benefits.** Prescribed medicines can be PBS/RPBS listed or non-PBS/RPBS listed. There can also be restrictions on use specified by the schedule. Restricted PBS Listed; Safety Net Threshold. There is a direct correlation between affordability of medications, the PBS/RPBS schedule that applies to them (if it applies at all) and the level of the safety net threshold. The amount of the co-payment reduces once the threshold is reached. Any increase or raising of the threshold has the effect of making medications more expensive. There can also be long (often 3-4 year) lead times in getting new products listed on PBS
- (2) **Access to ‘General Patient’ or ‘Concessional Patient Cards’ to become PBS beneficiaries.** To qualify for PBS benefits, general patients must possess a Medicare Card. Concessional patients must also hold a Medicare Card *plus* one of the following from Centrelink or the Department of Veteran Affairs (DVA) –
 - (i) Pensioner Concession Card;
 - (ii) Health Care Card; Repatriation Health Card for all conditions (Gold) under RPBS;
 - (iii) Repatriation Health Card for specific conditions (White) under RPBS; and
 - (iv) Repatriation Pharmaceutical Benefits Card (Orange).

Issues arising here are that not all people who are eligible to benefit from any of the above cards are able to easily prove their identity or are aware of their entitlement to own/use them eg homeless people and people from CALD backgrounds.

- (3) **Level of availability of generic alternatives to prescribed/premium brands.** Lack of information on the ‘interchangeability’ of branded and generic products acts as a common barrier to consumers having the assurance they need to feel safe in using the cheaper/cheapest medication. Whilst most commonly prescribed medications have a generic version available pharmacists are often reluctant to offer or promote this to consumers.
- (4) **Impact of a person’s illness, socio-economic status or living location on their earning capacity and ability to pay for prescription medicines.** Affordability is directly proportional to a person’s disposable income. The ‘well-heeled’ will by definition have less difficulty affording prescription medications than the poor. The more debilitating an illness (and the older the patient), the more likely it becomes that their earning capacity (and ability to work) will be diminished. People living in rural and remote areas/communities are also felt to be generally less affluent (and have more limited access to highly paid positions) than city dwellers.
- (5) **Financial impact of affording multiple medications versus a single medication.** Clearly, people whose medical condition(s) requires them to take a number of different, ongoing medications will spend more than those who perhaps need only one or two.

- (6) **Increased financial cost of requiring specialist treatment versus GP only.** There is a decided difference in the professional fees charged by GPs and specialist prescribers. For people requiring the more expensive services of specialists, the cost to them can be significantly higher (and less affordable) than those who can treat their illness with GP only visits.
- (7) **Cash flow problems according to the frequency and timing of requiring medication(s).** Whilst the ‘heavier/multiple users’ of medications face the greatest financial burden, this is often offset by them reaching the PBS Safety Net threshold quickly and thereafter reducing their per script costs for the year to a far more manageable level – until this is reached, however, cash flow is usually a real struggle. Affordability of medicines is not only diminished by the number, and regularity with which medications need to be purchased, but also by the presence of other bills that need to be paid at the same time. Often this is difficult to plan for eg the whole family comes down with the flu, the Type1 diabetic mother needs more insulin and the phone bill is due. Lack of prescribers who are still offering ‘bulk-billing’ is a real factor in consumers not being able to afford doctor visits. There is a flow on affect from this that can mean people who do pay the full GP fee for a visit may then not have the funds needed to fill the script they’ve been given.
- (8) **Level of ‘other non- medication costs’ associated with having and/or treating a particular medical condition.** A number of respondents interviewed spoke of medication only being *one part* of the cost associated with having an illness. The cost of fuel/transport to and from prescribing, dispensing and other healthcare services and facilities, special equipment eg wheelchair or asthma / insulin pump and even buying food from a corner store because you physically cannot get to a supermarket where products are cheaper are just some of the factors that impinge on affordability of medicines.
- (9) **Quantity of free medications available through hospital outpatient departments.** This is reducing as a result of public hospital cost cutting measures. HMA pointed out that this mechanism of supply would be further restricted as a result of the PBS Reforms being introduced in Victorian hospitals. As result of these Reforms hospital doctors in approved hospitals must now prescribe medications using the PBS arrangements at the time of discharge, or in non-admitted services. Consequently, patients’ co-payments (and the PBS safety net arrangements) now apply in these circumstances.

4.2.2 Affordability issues common to some groups

An issue common to *some* (but not all) groups around affordability barriers to accessing prescription medicine raised was anecdotal evidence of some people not fully complying with medicine directions in an attempt to make the dosage last over a longer period eg half their daily dosage to make it last longer and delay re-purchase. This was raised by chronic illness groups and some of the representatives of rural consumers.

Foster parents/carers (who may be simultaneously looking after several children) can also be faced with a lot of ‘out-of-pocket’ treatment/medication expenses due to them not being entitled to the same concessions/benefits as parents who are caring for their own

children. An example cited was of a ‘foster parent’ in the Northern Territory spending \$600 in one week when all six children in her care came down with a contagious illness.

4.2.3 *Affordability issues specific to particular groups*

Specific issues raised by particular groups were:

(1) **People with a Chronic Illness**

- **Diabetes:** Whilst cheaper generics are available for cardio-vascular disease (CVD), insulins are non-generic, affecting affordability for people with Type 1 diabetes. Whilst insulin pump consumables are listed on the PBS, the actual pump itself (worth \$6,000 - \$10,000 to buy) is not.
- **Epilepsy:** There was a suggestion during the interview that the use of generic alternatives is not always effective / efficacious, and changes to the regular brand of medication prescribed can lead to ‘seizure breakthroughs’. Many GPs do not feel adequately equipped to diagnose and treat patients with epilepsy and commonly refer them to specialist neurologists whose services cost more. Here, normal medical benefits may help to cover this.
- **Arthritis:** After examining this broad area of illness, a key affordability issue centred on people with osteoporosis. Some medications are only available under the PBS if a bone fracture actually occurs – this has the effect of disadvantaging people who need financial support from the PBS for medications to prevent fractures from happening.

(2) **People with a Mental Illness:** ‘Off label’ use is a cost issue for some people with a mental illness eg drugs that may be authorised for use in the management of schizophrenia may also be helpful in the management of bi-polar disease. This may not be an authorised PBS use and therefore result in the need for a private prescription where the full cost of the drug is borne by the user. Use of generics is another issue:

Stakeholder comment

“My doctor went berserk when he found out I was dispensed a generic version of the drug I was prescribed....the pharmacist checked their book and advised me they were the same.....I didn’t appreciate them acting as if they knew better than my doctor.I know of three different psychiatrists that insist on the use of non-generics.”

- (3) **People from Culturally and Linguistically Diverse (CALD) backgrounds.** Affordability was cited as a key issue, most particularly for older generations whose earning capacity has diminished and whose propensity to require prescription medication has increased with the ageing process. Cost issues are exacerbated by confusion around generic medicines and labelling, problems compounded by language difficulties of people from CALD backgrounds.
- (4) **People with a Disability.** Across the board, people with an intellectual disability tend to be high level users of prescribed medications, with most having a pension or

health card to assist with costs of purchasing. Here, the main discussion around affordability centred on situations where children with an intellectual disability are involved and specifically, the issue of eligibility/non-eligibility of people (carers/parents/guardians) to receive a Carers Pension or Carers Allowance and subsequently have possible access to Healthcare Card entitlements. Lack of financial support/concessions for medications needed for ‘non-mandated’ conditions can lead to real cash flow/affordability problems for families, particularly where there is more than one child requiring treatment of some kind. A further point raised is that bulk-billing is usually not offered by GPs and specialists in regional areas.

With respect to **physical disability**, affordability is a major issue. An underlying factor here is that the condition of many physically disabled people limits their ability to work and therefore lessens their earning capacity. This in turn can affect their entitlement to, for example, a Mobility Allowance, and their subsequent eligibility for a Healthcare Card. Whilst the Disability Support Pension financially assists many people in this group, there is evidence that people struggle to pay medical/medication costs – especially before the PBS Safety Net threshold ‘kicks in’. Whilst a variety of cheaper generic brands are available, there is also a belief that generics often do not work.

- (5) **People living in rural & remote areas.** Country people tend to be more ‘risk averse’ than city people and are less willing to change from buying their usual brand to purchasing a generic (despite it probably saving them money). Mention was made of people (particularly in country towns) ‘becoming loyal’ to one pharmacy where their medical information/medication history is recorded and that this can prevent them from wanting to utilise a different pharmacy who may offer certain products/medications at a cheaper price.
- (6) **Homeless people.** There is a direct correlation between homelessness and poverty. Medicine affordability is often affected because people in this group are often left with little disposable income. Homeless people who are ‘boarding’ have to spend a large proportion of their money on board. In situations where women are quickly forced to leave a domestic violence situation, they are commonly unable to take their belongings/assets – they then have the cost of resetting themselves up from scratch. Homeless people, especially under the age of 18 (without a driver’s licence) often have difficulty with proving their identity and/or income to access concessions.

4.3 ACCESSIBILITY ISSUES

4.3.1 Accessibility issues common to all groups

Issues common to all groups around accessibility barriers to accessing prescription medicine raised during the consultations were:

- (1) **Level of ease or difficulty accessing prescriber services.** 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. Geographic proximity to these prescriber services is the key determinant of ease of access to prescription medicine and the level of choice consumers have. But 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.

- (2) **Level of ease or difficulty accessing dispensing services.** In addition to pharmacies, 'dispensing services' also includes other mechanisms for supply, such as Section 100 Aboriginal Health/Medical Service outlets, remote area nurses, hospital dispensaries and Royal Flying Doctor Service 'Medical Bags/Boxes'. Geographic proximity to these dispensing services is once again the key determinant of ease of access to prescription medicine and the level of choice consumers have.
- (3) **Ability to access and utilise public and/or private transport.**

4.3.2 Accessibility issues specific to particular groups

Specific issues raised by particular groups were:

- (1) **People with a Chronic Illness** It was mentioned that many people in this group would welcome 'greater harmonisation' of services to minimise their need to visit multiple locations and providers to access their GP, specialist(s) and other professional healthcare services in order to manage their healthcare.
 - (i) **Epilepsy:** This is a key issue in respect of having access to both the 'right drug(s)' to control each individual's condition and also access to a prescribing neurologist. As with most chronic illnesses requiring specialist treatment, rural and remote residents are often forced to travel some distance to get the professional help and prescription medication they require. A further issue here is that there are sometimes legal restrictions on people with epilepsy being able to drive a car.
 - (ii) **Arthritis:** The effect arthritic conditions have on diminishing peoples' mobility raises the barrier of being less able to use public transport and/or drive a car to visit a pharmacy, GP or specialist eg rheumatologist. In rural and remote areas, geographic access to specialist prescribers in particular is even more difficult and can clearly affect timely diagnosis and treatment
- (2) **People with a Mental Illness.** Some stages of some mental illnesses would make driving a car to get to a prescriber, pharmacy or other dispensing outlet unsafe/difficult.
- (3) **People from CALD backgrounds.** Older people from CALD backgrounds often no longer drive and are reliant on their children or relatives to take them to doctor appointments or to visit pharmacies. Where language barriers and cultural preferences exist, this can result in patients travelling considerable distances to access a pharmacy run by a person of their own nationality.

- (4) **People with a Disability** Whilst not viewed as a major barrier for the intellectually disabled, the condition of many physically disabled people limits their ability to work and therefore lessens their earning capacity. It is common for this group to have difficulty (or a total inability) to drive a car - with the result that many must rely on family/friends for transport to doctors/pharmacists, use costly taxis or take public transport. With buses and trains, a common problem is that access to individual elements of these services is possible at some points of a 'broken' journey, but not at others. In rural and remote areas, where public transport services can be more limited than in cities and people must often travel greater distances to visit prescribers and dispensers, the difficulties are magnified even more.

Lack of equitable access to the built environment also tends to disadvantage people with physical disabilities in most aspects of their lives. Inaccessible premises with flights of stairs and no ramps often mean that they are unable to access health services such as doctors, dentists, physiotherapists and specialised services (e.g. women's health centres). It was felt, however, that pharmacy outlets were generally 'pretty good' in this regard.

While not many people know about or utilise 'e' pharmacies, there is a suggestion that purchasing over the internet can be a real plus in improving access to prescription medications and reducing per item costs. It is also believed that being able to 'phone order' repeat prescriptions to GPs and have pharmacies 'home deliver' medications was happening in some parts of Australia and needed to become far more prevalent.

- (5) **Indigenous People.** The extension of Section 100 supply arrangements from Aboriginal Medical Services (AMSs), currently limited to services in remote areas, could be extended to services in rural, regional and metropolitan areas.
- (6) **People living in rural and remote areas.** The increased use of qualified (remote area) Nurse Practitioners *could* serve to improve access to prescription medicines in some situations where a doctor was either unavailable or non-existent. Quality of roads can be an issue in remote areas; many are rough and unsealed and can become unusable in very wet conditions. Public transport is also often limited, unreliable and may require travelling some distance by car to get to. Ease or difficulty of access to pharmacy dispensing is invariably determined by whether or not a doctor/prescriber exists.
- (7) **Homeless people on Low Incomes.** Often homeless people have no personal transport, no telephone and no fixed address – moving around a lot also makes it harder for them access support services because of a lack of documentation .

4.4 AVAILABILITY ISSUES

4.4.1 *Availability issues common to all groups*

Issues common to all groups around availability barriers to accessing prescription medicine raised during the consultations were:

- (1) **Importance of people being able to access the ‘best available’ medications and new indications through pharmacies.**
- (2) **Importance of people being able to access the most up-to-date information on effectively treating and managing their particular ailment or illness through pharmacies.** There are clear indications that the implementation of informational services eg HMRs, CMI, varies greatly between pharmacy outlets. Where it is available, the “high-brow” level of language often used in CMI information was felt to make it inaccessible to the average consumer, with many putting it in the ‘too hard basket’ and simply not reading/ignoring the material.
- (3) **There was some issue of pharmacies not keeping stocks of certain medications, notably those at the more expensive end of the scale.**
- (4) **Communication and personal relationships.** The need for better communication/personal relationships between patients and pharmacists and improved access to (and promotion/awareness of) pharmacy information services like HMRs, CMI and the PBS ‘Medicine Line’ was highlighted in several interviews:

Stakeholder comment

“The level of personal relationship that people develop with their pharmacist or GP has a direct bearing on how much professional advice they receive and how aware they become of what information/services are available regarding their condition and/or medication choices. The more open the communication channels are the better the outcome.”

One stakeholder took this a step further:

Stakeholder comment

“Some people don’t even know of their entitlement to claim back costs on Medicare...there’s still a lot of work to be done in furthering consumer knowledge about the whole medical system”.

4.4.2 Availability issues specific to particular groups

Specific issues raised by particular groups were:

(1) People with a Chronic Illness

- (i) **Diabetes:** Because insulin is a refrigerated item, supplies are not stockpiled by pharmacies and need to be ordered in according to consumer demand. HMRs were seen to be operating at lower than optimum levels
- (ii) **Epilepsy:** Mention was made that some medications under PBS are not specifically listed for epilepsy but are used by some people with epilepsy to control/treat their condition.
- (iii) **Arthritis:** Whilst it was generally felt that consumers are becoming more aware of information and advisory support services in pharmacies (and that these were improving in quality and availability), little was known on the extent of usage of CMI, HMRs and the NPS ‘Medicine Line’.

- (2) **People with a Mental Illness.** Access to the ‘best available’ medications and new indications is a key issue in the effective treatment and control of each individual’s mental illness. Whilst pharmaceutical companies have clear incentives to gain and/or extend new indications approval for PBS listing of drugs/medications, the evidence collecting process they must follow is usually lengthy and can often take years. This can operate as a real barrier to people accessing medicines that would benefit their condition in a timely manner. SANE has been involved with the University of Sydney Pharmacy Department (Orange Campus) in looking at the role of pharmacists in the education and support of people suffering from depression. This role could be extended beyond the Orange district to other regions / jurisdictions and to other mental illnesses eg schizophrenia. There are indications that it is harder to get PBAC approval/PBS listing for drugs relating to mental illness compared to, for example, medications that assist with the management of HIV AIDS. There are also examples of drugs coming off patent shortly where there is minimal commercial incentive for manufacturers to market a generic drug because of the current PBS restrictions eg *Lamictal* (approved for epilepsy but also used to manage bi-polar disease). Current users face the prospect of there being no supply. Home Medication Reviews (HMRs) appear to be a rarity in the field of mental illness. Many people with mental illness tend not to ask too much about the drugs they are taking or what information services are available – a number also have low literacy, so they are generally not well informed about the impact of the medicines on their well-being. It is therefore most important that pharmacists make a real effort to advise individuals and ask them more questions about their condition in a pro-active manner – including whether they have taken the medication being dispensed before.
- (3) **People from CALD backgrounds.** Language difficulties (as well as cultural differences) are the key barriers impeding communication with health professionals and CALD peoples’ understanding of the safe and effective use of medicines. Low literacy/lack of education is also a factor here and the overuse of medicines was a finding linked to a general lack of knowledge regarding the quality use of medicine. It should be noted that many older immigrants have come from quite poor, rural backgrounds where access to medicines and advice was limited. People from first generation CALD backgrounds and experiencing language difficulties often do not read material if it is not in their own language. Some people are illiterate in their own language. Some have no written language at all. Word-of-mouth and workshops conducted within specific CALD community groups is often the most effective way for people to become aware of services available and understand them in their own language.

Stakeholder comment

“Some pharmacists actively employ bi/multi-lingual staff and that is to be applauded.....others can be rude and fail to treat people whose command of English is not that good as valued customers.....the personality of the pharmacist is critical to developing a friendly, respectful relationship and rapport that improves communication.”

- (4) **People with a disability** Way beyond the affordability of medication in terms of significance was access to information and advisory services, particularly for parents/carers of children suffering from an **intellectual disability**. What these people most need/want is for pharmacists and GPs/specialists to spend time becoming involved as ‘partners’ in assisting them with the planning, control and management of their children’s condition. Not just in the practical sense of achieving the best possible medication outcomes with minimal adverse side effects, but also the psychological sense of helping children cope better eg educationally and socially; and helping parents/carers to have the knowledge and understanding needed to cope with changeable patient behaviours and to feel that they are more “on top of the situation”

With respect to physical disability, little is known about the availability of HMRs and CMIIs were not believed to be widely used.

Stakeholder comment

“There’s a real need for pharmacists to advertise these information sharing services and increase peoples’ awareness of their very existence.....a brochure outlining all the various things offered would be really helpful.....possibly even a generic TV campaign could be used.”

- (5) **Indigenous people.** An arrangement for accessing special medications not formally listed on the PBS for certain palliative care drugs could be extended to drugs that are usefully prescribed for some illnesses more common to Indigenous people.
- (6) **People living in rural and remote areas.** Little specific knowledge of CMI or HMR services was evident. Generally, the principle behind these services is applauded, but it was felt they are currently very limited in their implementation by most rural and remote pharmacies. Where pharmacies do exist, there are questions as to whether rural and remote pharmacists have the physical time, competence and appropriate incentive to provide HMR and CMI services. Some issues exist with pharmacies not always stocking what doctors are prescribing. Patients then have to either wait for their medications to be ordered in or for the pharmacist to contact the prescriber to alter the brand to dispense. A contributing factor here is that different visiting ‘locum GPs’ often have their preferences for prescribing medicines of certain brands or types. With regard to the imprest generally available to Remote Area Nurses (RANs), this tends to incorporate generic and ‘core drugs’ with real limitations on branded choices – particularly where there is a lack of a central (and well-stocked) pharmacy in the vicinity. This situation in remote places often compromises the level of efficacious treatment compared to urban areas. It was felt that state and territory agreement on a standardised protocol on drug availability would help to address this issue. Other barriers to accessing prescription medicines were identified as low literacy levels, language difficulties and cultural differences, particularly with respect to indigenous communities.
- (7) **Homeless people on low incomes.** Many homeless people do not use a regular doctor, pharmacist or clinician. Many also feel uncomfortable about using

mainstream services. The implications here are that their medication, advice and information needs are more likely to be met via distribution sources that more directly cater to their situation and mindset.

4.5 ACCEPTABILITY ISSUES

4.5.1 *Common acceptability issues and issues specific to particular groups*

There were no readily apparent common issues around acceptability. Even within specific consumer groups (eg CALD) there appear to be major differences affecting acceptability issues. This is further accentuated by the individual needs and expectations of people with different kinds of illnesses. Issues significant to some groups were:

- (1) **Lack of privacy in discussing personal/sensitive medical conditions in pharmacies.** There are also specific privacy difficulties and sensitivities for patients who need to be accompanied on their visit by a carer/friend/family member/or interpreter (CALD situations). They are often unable to discuss personal matters with their pharmacist without their “minders” being privy to the conversation - which can often be more embarrassing than a stranger overhearing.
- (2) **Lack of sensitivity by pharmacists towards understanding and responding to the different cultural needs and expectations of different groups in society eg indigenous, CALD.**
- (3) **Propensity of some prescription drugs dispensed to produce nasty side-effects.**
- (4) **Lack of involvement by some pharmacies in offering advisory and informational services.**
- (5) **Lack of time of some pharmacists to provide quality one-on-one consultations with customers.**
- (6) **Professional development around communication skills.** Whilst the importance of doctors and pharmacists being good communicators has been covered in many interviews, it has been suggested that development of their personal skills and ‘bedside manner’ with patients was so crucial to building trust relationships (and improving the consumer experience of accessing medicines) that further opportunities for professional development of doctors in this area should be considered.
- (7) **Complementary medicines.** On the topic of whether ‘complementary/alternative’ medicines posed a possible threat to consumer demand for prescription medications, it is generally felt that the huge interest in natural/herbal products and the large amounts of money people are now spending on them suggest that they are indeed a major competitor.

Stakeholder comment

“There is strong anecdotal evidence emerging that people are actually substituting complementary medicines for prescribed ones – not just purchasing it in addition. It’s usually a bit cheaper and people sometimes feel that ‘herbal’ has to be better for your body than prescription drugs.”

4.5.2 Acceptability issues specific to particular groups

Specific issues raised by particular groups were:

(1) People with a Chronic Illness

- (i) Diabetes:** Creating private ‘in-pharmacy’ areas/settings for patient/pharmacist consultation and advice on insulin/injecting was cited as a needed improvement here – there are real sensitivities among new users, with some wanting to keep their condition secret from their employers who may see it as an unacceptable workers’ compensation risk. Some pharmacies accept single use needles back, but some do not. There are again sensitivities among insulin injecting people with diabetes of not wanting to be seen visiting needle exchange centres which are most often associated with illicit drug use and/or addicts.
- (ii) Epilepsy:** Some medications for epilepsy produce unpleasant physical side effects. Because of the social stigma attached to epilepsy, it is also felt that more patient privacy is required in pharmacies/dispensing outlets to discuss matters.
- (iii) Arthritis:** It appears there is increasing consumer preference for natural products eg glucosamine as opposed to drugs with side effects. It was also noted that some arthritis sufferers whose hand functions are impaired have difficulty with opening the packaging of their medications.
- (iv) Asthma:** Points raised here was that asthma inhaler devices can be difficult for some people to use, particularly young children and those with arthritic conditions. The issue of pharmacists fully explaining the side effects of asthma medications, especially the steroidal kind, was also thought to require improvement.

- (2) People with a Mental Illness.** Greater sensitivity to their need for support by pharmacy staff is needed. To improve the acceptability of pharmacy services to people with a mental illness, pharmacies must become more aware of the anxieties/fears people often have about going to new/unfamiliar places and also changing medications. They need to realise that their professional atmosphere, bright lights, often ‘slick’ modern décor and well presented staff can be very intimidating/confronting to many who suffer from mental illness.

Stakeholder comment

“ a more gentle and welcoming approach is what is needed to help them feel more comfortable about entering a pharmacy environment”.

- (3) **People from CALD backgrounds.** There is evidence to suggest that older people in this group often feel uncomfortable about asking questions of doctors and take a relatively passive role in dealing with health professionals - who they generally hold in high esteem. Beyond language difficulties and not feeling educationally equipped to ask the right questions and usually seeing it as a doctors' role to 'tell them' the medical answers, there is an issue among Asian communities in particular that it is disrespectful to query what they are told by doctors/pharmacists. It was thought that the expectations of people in this group often "aren't that high" regarding the quality of pharmacy services/products offered. Many newer arrivals to Australia come from oppressed, war-torn countries – so they are very accepting of what they are told by both prescribers and dispensers of medications.
- (4) **People with a Disability** The physical layout of pharmacies appears to be a factor affecting the behaviour of children with an intellectual disability. Where aisles are narrow and space is cramped, they tend to be much harder for carers/parents to control/keep happy than in places which are more open and feel less crowded. For those with physical disabilities, it was emphasised that increasing the use of modern communications to improve consumer access to pharmacies would be welcomed eg phone advice and phone ordering of medications. Some pharmacies could do more to explain the potential side effects of certain medications to relieve patient/user anxieties over not knowing if they were having a 'normal' reaction.

Stakeholder comment

"I don't think pharmacies are particularly intimidating to the physically disabled...although people from CALD backgrounds may encounter some degree of language or cultural difficulty".

- (5) **People living in rural & remote areas.** A key issue raised here centred on lack of patient/customer privacy in pharmacies and the problem of 'small town gossip'. A young woman seeking to discuss a sensitive personal issue eg pregnancy testing, or a person suffering from HIV may have to travel far away from their local pharmacy to avoid being the 'talk of the town'.

4.6 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:

- (1) 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.

- (2) 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’ scepticism of pharmaceutical companies’ motivations. 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.

Stakeholder comment

“There is strong anecdotal evidence emerging that people are actually substituting complementary medicines for prescribed ones – not just purchasing it in addition. It’s usually a bit cheaper and people sometimes feel that ‘herbal’ has to be better for your body than prescription drugs.”

Stakeholder comment

“Like most people with a chronic illness, those with asthma are always looking for ways to improve their lot in life...it should be said though that there are some complementary medicines which can be very dangerous, particularly when taken in combination with other prescribed medications. It is essential for people to speak with their doctor first and always advise a pharmacist of their asthma condition before buying any over-the counter products”.

Stakeholder comment





“These days, people are moving more and more towards over-the-counter ‘health products’ that promote personal wellbeing and prevent conditions occurring....the traditional way has been for GPs to treat conditions once they’re apparent.”



4.7 INDICATIVE RANKING OF ACCESS MEASURES BY CATEGORY

As part of the interview process, respondents were asked to rank the four key access measures of Accessibility, Availability, Affordability and Acceptability in terms of their relative importance to the stakeholder groups they represented. The following is a

summary of their responses and should be read as ‘1’ equalling most important and ‘4’ equalling least important. A diagrammatic representation of the significance of each factor is presented in the right hand column of the table, with a greater area of ‘blocking out’ signifying increase importance of this access barriers to the population group.

Table 4.2: Ranking of Access Measures by Category

<p>People with a chronic illness</p> <ol style="list-style-type: none"> 1. Accessibility 2. Availability 3. Affordability 4. Acceptability 	<p>People with Chronic Illness</p> 
<p>People with a mental illness</p> <ol style="list-style-type: none"> 1. Availability & Affordability (equal ranking) 2. 3. Acceptability 4. Accessibility 	<p>People with Mental Illness</p> 
<p>People with a disability</p> <ol style="list-style-type: none"> 1. Affordability 2. Availability 3. Accessibility 4. Acceptability 	<p>People with a Disability</p> 
<p>Indigenous people</p> <ol style="list-style-type: none"> 1. Accessibility 2. Acceptability 3. Affordability 4. Availability 	<p>Indigenous People</p> 

<p>People living in rural & remote areas</p> <ol style="list-style-type: none"> 1. Accessibility 2. Affordability 3. Availability 4. Acceptability 	<p>People living in rural & remote areas</p> 
<p>People from Culturally and Linguistically Diverse (CALD) backgrounds</p> <ol style="list-style-type: none"> 1. Availability 2. Acceptability 3. Affordability 4. Accessibility 	<p>People from CALD backgrounds</p> 

Although qualitative in nature, the material presented in Table 4.2 serves to emphasise that the nature of access barriers to prescribed medicines experienced by different groups varies.

Based on the discussions with each of the stakeholder groups, HMA also identified areas for possible further research that were of relevance to the group. These possibilities were identified by HMA as a result of examining the summary of the interview discussion. The *future research pointers* can be categorised under the four dimensions of access as well as being identified by the different consumer categories. They are summarised in Table 4.3, along with the main issues from the stakeholder consultations.

Table 4.3: Issues Raised During Consultation and Future Research Pointers derived from Consumer Peak Body Interviews

	Affordability	Accessibility	Availability	Acceptability
<i>Issues common to all groups raised through the consultation process</i>	<p>Affordability is determined by listing on the PBS/RPBS.</p> <p>People have difficulty in establishing identity to establish general or concessional patient entitlement.</p> <p>‘Interchangeability’ of branded and generic products: lack of information.</p> <p>Impact of person’s illness, socio-economic status or living location on earning capacity and ability to pay for prescription medicines.</p> <p>People whose medical condition(s) requires them to take a number of different, ongoing medications will spend more than those who perhaps need only one or two.</p> <p>People requiring specialist services: can face significantly higher costs.</p> <p>Frequency and timing of requiring medication(s) can cause cash flow problems.</p> <p>Many patients face non-medication costs associated with their medical condition.</p> <p>Quantity of free medications available through hospital outpatient departments.</p>	<p>Access to specialists to prescribe medicines can be limited.</p> <p>Difficulty in accessing a dispensing service where community pharmacies are unavailable.</p> <p>Lack of access to transport can affect access.</p>	<p>Important to be able to access ‘best available’ medications and indications through pharmacies.</p> <p>Important for people to be able to access the most up-to-date information on effectively treating and managing their particular ailment or illness through pharmacies.</p> <p>Some pharmacies do not keep stocks of certain medications, notably those stocks at the more expensive end of the scale.</p> <p>Pharmacists do not always have good communication/personal relationships with patients.</p>	<p>Lack of privacy in discussing personal/sensitive medical conditions in pharmacies.</p> <p>Lack of sensitivity by pharmacists towards understanding and responding to the different cultural needs and expectations of different groups in society.</p> <p>Propensity of some prescription drugs dispensed to produce unpleasant side-effects.</p> <p>Lack of involvement by some pharmacies in offering advisory and informational services.</p> <p>Lack of time of some pharmacists to provide quality one-on-one consultations with customers.</p> <p>Need for professional development around communication skills by some pharmacists.</p>

	Affordability	Accessibility	Availability	Acceptability
Specific Groups				
Chronic Illness				
<i>Issues specific to chronic illness raised through the consultation process</i>	<p>Can be a greater reliance on non-generic drugs, reducing the scope for substitution.</p> <p>Some argue that use of generics is not always efficacious.</p> <p>PBS indications are not always responsive to need.</p>	Continuity of care across service settings makes it difficult for individuals to manage their own healthcare.	Medications for some diseases are not routinely stocked.	Lack of privacy to discuss personal / sensitive conditions within pharmacies.
Future research pointers arising from analysis.	<p>1. Frequency of 'off-indication' use/ number of PBS listed drugs that are being prescribed for osteoporosis (or other conditions) that are non-PBS compliant.</p> <p>2. Efficacy of variations in PBS and RPBS listings.</p> <p>3. Circumstances / criteria for fast tracking the PBAC approval process for different categories of new drugs.</p>	<p>4. Number and appropriateness/ effectiveness of PBS conditions placed on circumstances for prescribing of medication.</p> <p>5. Appropriateness of drugs being classified under the s100, Highly Specialised Drugs program.</p>	<p>6. Focus group analysis of what limits consumers accessing CMI and initiating HMRs.</p> <p>7. Focus group analysis of what limits community pharmacists in the promotion of CMIs and triggering HMRs [this area may already have been examined in the external evaluation of the HMR program].</p> <p>8. Focus group analysis of what limits doctors in initiating HMRs [this area may already have been examined in the external evaluation of the HMR program].</p> <p>**Findings from the above research could be used to develop promotional / advertising programs in each stakeholder area.</p> <p>9. Scope for specification of a minimum formulary within community pharmacies (content, size)</p>	<p>10. Development of a program for improved community pharmacist customer management techniques.</p> <p>11. Survey pharmacies to identify the proportion that have appropriate patient consulting areas.</p> <p>12. Survey pharmacies to identify the proportion that run needle exchange services.</p>

	Affordability	Accessibility	Availability	Acceptability
Mental Illness				
<i>Issues specific to mental illness raised through the consultation process</i>	'Off label' use is a cost issue for some people with a mental illness	Some stages of some mental illnesses would make driving a car to get to a prescriber, pharmacy or other dispensing outlet unsafe/difficult	PBS listing processes can operate as a real barrier to people accessing medicines that would benefit their condition in a timely manner.	Greater sensitivity to the need for support by pharmacy staff is needed.
Future research pointers arising from analysis.	<p>13. Frequency of off-indication use / number of PBS listed drugs that are being prescribed for non-PBS compliant reasons, generating a private script, by illness/condition.</p> <p>14 Investigate the total cost of having a mental illness[or other condition] ie. not just for medications but all the associated add-ons (travel time and costs)</p>		<p>15.Trial use of pharmacists in:</p> <ul style="list-style-type: none"> - the education and support of people suffering from depression, beyond the Orange district to other regions / jurisdictions (SANE has had preliminary discussions with the Victorian Guild for such a rollout); and -other mental illnesses eg psychosis; <p>16. Trial new modes of triggering HMRs:</p> <ul style="list-style-type: none"> - from hospital at the time of discharge after a mental illness admission; and -working directly with community mental health case workers. <p>17. Develop packages for training mental health workers in mental illness medication management.</p>	

	Affordability	Accessibility	Availability	Acceptability
Disability				
Issues specific to disability raised through the consultation process	<p>People with intellectual disability tend to be high level users of medication.</p> <p>The condition of many physically disabled people limits their ability to work and therefore lessens their earning capacity.</p>	<p>The condition of many physically disabled people limits their ability to work and therefore lessens their earning capacity.</p> <p>It is common for this group to have difficulty (or total inability) to drive a car; they must rely on family/friends for transport to doctors/pharmacists, use costly taxis or take public transport.</p> <p>Inaccessible health service premises can be a problem.</p>	<p>Access to medicine information and advisory services can be a problem for people with an intellectual disability.</p>	<p>Physical layout of pharmacies can be problem for people with disabilities.</p>
Future research pointers arising from analysis.		<i>18. Proportion of prescriptions purchased over the internet or via phone delivery and the availability of these different purchasing channels.</i>		
Indigenous				
Issues specific to Indigenous people raised through consultations		<p>S100 supply arrangements could be extended to rural, regional and metropolitan areas (currently restricted to remote).</p>	<p>Special access arrangements to palliative care drugs could be extended for drugs used for common illnesses.</p>	
Future research pointers arising from analysis.			<p><i>19. Scope for extending current S100 (remote area only) arrangements to also apply to rural and urban areas.</i></p> <p><i>20. Creation of special list of medications applicable to 'high incidence' indigenous ailments (based on special medication list for Palliative Care).</i></p>	

	Affordability	Accessibility	Availability	Acceptability
Rural & Remote				
Issues specific to rural and remote people raised through consultations	Country people more 'risk averse' and less willing to change from buying their usual brand to purchasing a generic.	Increased use of qualified (remote area) Nurse Practitioners <i>could</i> serve to improve access to prescription medicines.	Appears to be limited use of HMRs and CMI in rural and remote areas.	Risk of 'small town gossip' is increased by lack of access to privacy in pharmacies.
Future research pointers arising from analysis.	<p>21. Investigate whether transport/distribution costs make prescription drugs more expensive in rural and remote areas compared to city/urban centres ie is the average price beneath the maximum patient co-payment level higher in non-metropolitan areas?</p> <p>22. Develop a promotional campaign targeted at regional consumer, advising on the availability of generic drugs.</p>	<p>23. Document alternatives for pick-up and delivery of prescriptions in rural and remote areas and</p> <ul style="list-style-type: none"> - establish the level of Pharmacy Board support for these alternative arrangements; and -develop submissions to Boards seeking greater uniformity of approach across state and territories. <p>24. Document RFDS operational arm policies around content and delivery of medical boxes and seek greater uniformity across operational arms.</p> <p>25. Assess the adequacy of financial incentives for pharmacies to remain operating in rural and remote areas.</p>	<p>26. Focus group analysis of what limits consumers accessing CMI and initiating HMRs in rural and remote areas.</p> <p>27. Focus group analysis of what limits community pharmacists in the promotion of CMIs and triggering HMRs in rural and remote areas [this area may already have been examined in the external evaluation of the HMR program].</p> <p>28 Focus group analysis of what limits doctors in initiating HMRs in rural and remote areas [this area may already have been examined in the external evaluation of the HMR program].</p> <p>29. Investigate scope for greater standardisation in prescribing/dispensing guidelines for RANs eg roll-out of the CARPA guidelines (which currently only have legal status in the Northern Territory) to other Australian states and territories.</p> <p>30. Explore scope for establishing a</p>	<p>32. Survey pharmacies to identify the proportion that have appropriate patient counselling areas.</p>

			<p><i>universal drug imprest list to create greater uniformity of what medications RAN personnel keep on hand in their pharmacy cupboard</i></p> <p><i>31 Assess scope for roll-out of the remote area pharmacist model operating in the Ngaanyatjarra Health Service in Western Australia. Under this model a pharmacist has been appointed to provide a range of services including clinic reviews (of RAN dispensing activity), HMRs, imprest stock checks, advice to individual patients eg at 'sorry camps'.</i></p>	
CALD				
<i>Issues specific to CALD communities people raised through consultations</i>	Cost issues are exacerbated by confusion around generic medicines and labelling, problems compounded by language difficulties of people from CALD backgrounds.	Patients can travel considerable distances to access a pharmacy run by a person of their own nationality.	Language difficulties and cultural differences are the key barriers impeding communication with health professionals and CALD peoples' understanding of the safe and effective use of medicines.	Older people in this group often feel uncomfortable about asking questions of doctors and take a relatively passive role in dealing with health professionals
Future research pointers arising from analysis.				

Homeless				
<i>Issues specific to homeless people raised through consultations</i>	Homeless people who are 'boarding' have to spend a large proportion of their money on board.	Lack of documentation makes it more difficult to access medications	Many homeless people do not use a regular doctor, pharmacist or clinician.	
Future research pointers arising from analysis.	<p>34. Little is known regarding the extent of homeless peoples' use of prescription medicines.</p> <p>35. Investigate the extent to which changes to tenancy arrangements for public housing may increase the risk of marginalised people being 'pushed' into homelessness.</p> <p>36. Establish the scope for establishing a 'medicines' funding pool for homeless people, to be administered by Supported Accommodation Assistance Providers.</p>			
Alternative/ Complementary Medicines	<p>37. Investigate the extent to which consumers are using non-prescription medications to 'self treat/manage' chronic illnesses and medical conditions generally and to also identify the impact this is having on their demand for prescribed medications.</p> <p>38. Within the above, explore the extent to which consumers are substituting non-prescription/OTC health products for prescription medications.</p>			

This list of future research pointers was provided to the EAG and examined for areas where additional work by the *Access to Medicines Consortium* was needed. The process of analysing these priorities is described in the next chapter of this report.

5

Synthesis of findings and next steps for research

In this chapter, we present the approach of the EAG to the individual *future pointers for research* identified through the consultation process. We also describe the *high priorities for research* developed in consultation with *Consortium* members, after consideration of the findings from the initial project phases. The priorities described in this chapter will provide the basis for formulating more detailed research briefs at the conclusion of this project. The content of this chapter is based on a brainstorming session conducted with representatives of the EAG on 20 June 2005 which was then summarised by HMA.

5.1 STAKEHOLDER CONSULTATIONS: CONSORTIUM RESPONSE

Representatives of the EAG examined the list of the *future pointers for research* identified from the interviews with consumer peak bodies, listed in Table 4.2 in the previous chapter. The EAG 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, they observed that most of the *research pointers* were being or could be addressed by key stakeholders with prime program responsibility in the area. The *future research pointers* categorised in this way, and the program area that is or could be affected if the issue is to be addressed, are listed in Table 5.1.

Table 5.1: Categorisation of a Selection of the *Future Research Pointers*, by Primary Medicines Program Impacted and Key Stakeholder with Prime Responsibility

Program	Key stakeholder(s) with Prime Program Responsibility	Micro Future Research Priority (a)
Quality Care in Pharmacy Program	Guild	15,16,17, 23,38
Consumer Medications Information	Department of Health and Ageing (DoHA) / Guild	11,12,12,32,33,34
Home Medication Review	DoHA / Guild	11,12,12,32,33,34
S100 - Indigenous	DoHA, NACCHO	24,25,32,33,34
S100 – Highly Specialised Drugs	DoHA	10
PBS: process for managing what is listed in the schedule and conditions that apply	DoHA, Pharmaceutical Benefits Advisory Council	6,7,8,9,10,
Rural remote programs (funded under the Third Pharmacy Agreement)	Guild	14,26,27,28, 29, 35,36,37

(a) Reference numbers refer to the numbered priorities in Table 4.2

The *Access to Medicines Consortium* members observed that they had no major role to perform in the short term in relation to the future research priorities listed in Table 5.2. This is because there is already a stakeholder with prime responsibility for carriage of the program area. It was noted this position may need to be re-assessed in the medium to longer term if there has been no progress by the primary stakeholder and the access barrier still continues to be a concern.

Although most of the research proposals identified as a result of the consultations fell within the category of being outside the *Consortium's* research brief, there were some research pointers that 'fell between the cracks'. These are listed in Table 5.2. The *Consortium* was more comfortable with assuming responsibility for progressing research in these areas.

Table 5.2: *Future Research Pointers* where there is No Primary Health Program Addressing the Issue and No Key Stakeholder with Prime Responsibility

Area	Micro Future Research Priority
Homelessness	40,41,42
Case management of patients with complex conditions not being addressed by HMRs	19, 20, 21

(a) Reference numbers refer to the numbered priorities in Table 4.2

5.2 RATIONALE FOR CONSORTIUM INVOLVEMENT IN RESEARCHING CONSUMER ACCESS BARRIERS

From this categorisation it is now possible to more accurately describe how the *Access to Medicines Consortium* perceives its role in defining its research brief in relation to consumer access barriers. This is to:

- leave stakeholders with prime responsibility for managing an existing program to respond to access concerns. 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 at the ‘brainstorming’ session on 20 June 2005 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 the PBS 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 in section 5.3.

5.3 DESCRIPTION OF HIGH PRIORITY RESEARCH TASKS ON ACCESS BARRIERS

5.3.1 *High Research Priority #1: re-designing aspects of the PBS and MBS safety nets to better address affordability*

Background to Research Need

Consultations with consumer stakeholder groups confirmed that policy settings for the PBS safety net operate to:

- enable low income individuals and families eligible for certain Commonwealth Government pensions and allowances to access PBS medicines at concessional rates; and
- protect individuals and families from large/excessive overall medication expenses.

However, there was criticism during the consultation process regarding *the time it takes for the safety net arrangements to take effect* for an income unit. This can be highly variable, according to:

- the size of the income unit;

- the number of income unit members that have one or more chronic or short-term illnesses; and
- the nature of those illnesses and the medication and clinical support required to manage the condition(s).

Variations in these circumstances probably result in horizontal inequities in the net resources of income units after medication outlays, despite having a similar income unit structure.

Target Group for Research: low income groups that benefit from the PBS safety net arrangements and income units whose income is marginally above the current income eligibility thresholds for the safety net. The research could also encompass the distributional impacts of the MBS because the two sets of policy settings impact on consumers in tandem.

Research Objective

Preliminary specification of the research could seek to assess the distributional impacts of different PBS and MBS safety net settings and arrangements in detail. Options for examination could include:

- **Option 1:** relaxation of ‘within year’ PBS safety net arrangements for heavy medication users eg safety net to take immediate effect for all income unit members who reached the safety net in the previous year and, say, whose GP certifies that their condition is likely to continue for a further 12 months;
- **Option 2:** pooled MBS/PBS safety net;
- **Option 3:** as for option 2 plus an additional allowance for chronic illness costs;
 - a variant of this option would be to have different allowance levels according to the nature of the chronic illness;
- **Option 4:** as for option 3 but assessing the impact on other household expenditures.

For each option the research could seek to quantify:

- the number of income units that are ‘winners’ and ‘losers’, including at different time periods (fortnightly) within a financial year;
- the estimated outlays (consumer co-payments) on PBS items by income unit type; and
- the costs to government.

Suggested Research Method

An assessment of the income distribution impacts on income units of different PBS safety net settings can be undertaken using micro simulation techniques. This combines income unit level data from household expenditure surveys with national health surveys and administrative data from the PBS.

The National Centre for Social and Economic Modelling (NatSem), in partnership with Medicines Australia, has developed such a model, called *Medisim*. Whilst primarily developed to test the impacts of different PBS safety net design settings, NatSem has

advised that with refinement *Medisim* can be also be used to assess *within year impacts on different income units* of current and proposed PBS policy settings.

An additional *Medisim* module that will also enable examination of the distribution impacts of changing the Medical Benefits Schedule safety net arrangements is currently being constructed. NatSem has advised that this should be completed by early 2006.

Potential Suppliers

NatSem is the only known supplier of a micro simulation model that can test the distributional impacts of different PBS design settings.

Suggested approach to Facilitating Research

The limited supply of modelling expertise in this area means that NatSem could be approached to undertake the assignment via invited tender.

Estimated Elapsed Time to Complete

Around 12 months.

5.3.2 High Research Priority #2: complex care patients – ensuring enhanced medication access and management

Background to Research Need

In the last five to ten years, there have been significant developments around the design of programs to ensure consumers' access to medicines is optimal and fully understood. Initiatives include the introduction of Residential Care Medication Management Reviews (RMMRs), Home Medication Reviews (HMRs), Consumer Medicines Information, and the National Prescribing Service and its associated public education activities.

More recently in the Victorian public hospital system, there have been trials of processes to systematically identify discharge patients at risk of medication non-compliance. The Pharmaceutical Reform Working Group, which reports to the Australian Health Ministers Advisory Group, is now undertaking a study to examine the scope for introducing a Hospital Home Medication Review Program for 'at risk' patients at the time of discharge.

However, members of the *Access Consortium* are concerned that there remains a group of complex care patients:

- who are at risk of insufficient access to medicines; or
- who are experiencing polypharmacy issues and have only marginal engagement with the primary care system.

Target Group for Research: complex care patients in the community, at risk of insufficient access to medicines or experiencing polypharmacy, and compromising people with:

- multiple disease states; and/or
- complex psychosocial needs; and/or
- depression and anxiety; and/or
- cognitive impairment.

Many of these patients encounter the public health system, particularly emergency departments, and are ‘bounced back’ into the community after stabilisation, without necessarily addressing their underlying medical or social needs, including the appropriateness of their medication regime, or lack of it.

Research Objective

The objectives of the project would be to:

- establish the number of complex care patients whose medication needs are not addressed by current program arrangements (HMRs and RMMRs);
- establish what other programs, if any, are in place to manage the medication needs of complex care patients who are not involved in post hospital discharge programs or HMRs; and
- design principles for programs to better manage the medication needs of these patients.

Suggested Research Method

The project could involve a scoping survey of service providers, including public hospital emergency departments, state/territory departments and other stakeholders to:

- assess what proportion of emergency department attendees have medication issues that are relevant to management of their complex medical problems;
- establish current usage made of HMR and RMMR processes to manage these patients;
- identify other programs and processes that are currently in place to manage these patients; and
- seek stakeholder views on the design principles for better managing the medication needs of these patients.

Potential Suppliers

A generic consulting firm could undertake this review process.

Suggested approach to Facilitating Research

Open tender.

Estimated Elapsed Time to Complete

Around 9 months.

5.3.3 High Research Priority #3: medicines access – identifying the impact of macro drivers of demand – income, geography, socio-economic status.

Background to Research Need

This study (see Chapter 3, Section 3.5) examined Australia-wide admission rates for ambulatory care sensitive conditions. The analysis concluded that there was evidence of a statistically significant relationship between the rates of admission for these conditions, according to where people lived and their socio-economic status. The underlying drivers for these relationships need to be examined.

Target Group for Research: people admitted to hospital for ambulatory sensitive care conditions in a stratified sample of local government areas (LGAs) that cover varying levels of socio-economic status and geographic remoteness. For initial design scoping purposes, this could comprise:

- three LGAs with a remoteness ranking of ‘0’ and three different SEIFA rankings of, say, ‘10’, ‘5’ and ‘1’;
- one LGA with a remoteness ranking of ‘1’ and a SEIFA category of, say, ‘5’;
- one LGA with a remoteness ranking of ‘2’ and a SEIFA category of, say ‘1’; and
- one LGA with a remoteness ranking of ‘3’ and a SEIFA category of, say ‘1’.

Research Objective

The purpose of this project would be to explore the relationship between socio-economic status / geographic location, and admissions for ambulatory sensitive care conditions. In particular, it could seek to assess the impact that access to medicines, or lack of it, may have on differences in admission rates for ambulatory care sensitive conditions.

Suggested Research Method

The project could seek to:

- describe the socio-economic profile of the LGA using ABS census data;
- describe the socio-economic characteristics of individuals admitted for ambulatory sensitive care conditions in each of the selected LGAs, using de-identified records from the state/territory admitted episodes database, and identify:
 - how the socio-economic of patients vary by SEIFA/remoteness category;
 - the location of service delivery for the ambulatory care admission (which may not be the same as the LGA of residence);
- describe the health service delivery system accessible to residents in each of the sample LGAs. This would include information on:
 - access to primary medical services, including GPs (numbers of GPs / HIC claims) and community health services;
 - access to community pharmacies (number of pharmacies / HIC claims),
 - acute and sub-acute service delivery points;
 - number of HMRs and CMIs; and
 - availability of residential care places;
- interview the relevant GPs and pharmacists about consumers’ knowledge of medicines;

- there could be a prospective review of inpatient admissions and casualty/emergency attendances to identify, and follow-up, admissions and attendances potentially caused by lack of access to medicines. Patients would be invited to take part in a study to identify factors that lead to the admission/attendance. The study could examine the access to medicine issues in each ambulatory sensitive care condition group; and
- the follow-up of this analysis could be the establishment of a working group of Area Health Service/regional health service, Division of GP, community nurses, and consumer groups, with technical support, to review the results, and identify and trial methods of improving access on an area/region by area/region basis.

Potential Suppliers

A generic consulting firm could undertake this review process in association with epidemiologists and specialist advisers in each of the ambulatory sensitive care condition areas.

Suggested approach to Facilitating Research

This project is complex in nature. It would therefore be wise to have a restricted tender limited to organisations with known capability in these areas of research.

Estimated Elapsed Time to Complete

Around 18 to 24 months.

5.3.4 High Research Priority #4: facilitating access to medicines by homeless people.

Background to Research Need

Consultations during the project with the Australian Federation of Homelessness Organisations (AFHO) identified that there are three broad areas of homelessness: youth, women and general (which can include men who have experienced family breakdown, illegal immigrants and asylum seekers, people of CALD backgrounds). Those discussions also indicated that the homeless can have high health needs. Many suffer from chronic or mental illnesses, psychiatric disability, communicable diseases (eg HIV/AIDS, viral hepatitis), and drug or alcohol dependence.

Target Group for Research: homeless people

Research Objective

The project could seek to establish ways in which the health of homeless people can be improved through enhanced access to medicines.

Suggested Research Method

A sample of Supported Accommodation Assistance Program (SAAP) providers could be interviewed to identify barriers to accessing medicines encountered by homeless people. At a minimum, this interview process should include 2 or 3 service providers that target each of the categories listed above, ideally in more than one state.

Using the SAAP service management as a guide, local GPs and community pharmacists seeking to support the clientele of the local service could be interviewed to obtain their views about the medicine access barriers.

Based on the field work, the project could formulate and cost policy options for enhancing access to medicines by homeless people.

Potential Suppliers

A generic consulting firm could undertake this policy formulation process.

Estimated Elapsed Time to Complete

Around 4 to 6 months.

5.4 OVERVIEW OF APPROACH TO RESEARCH PRIORITISATION

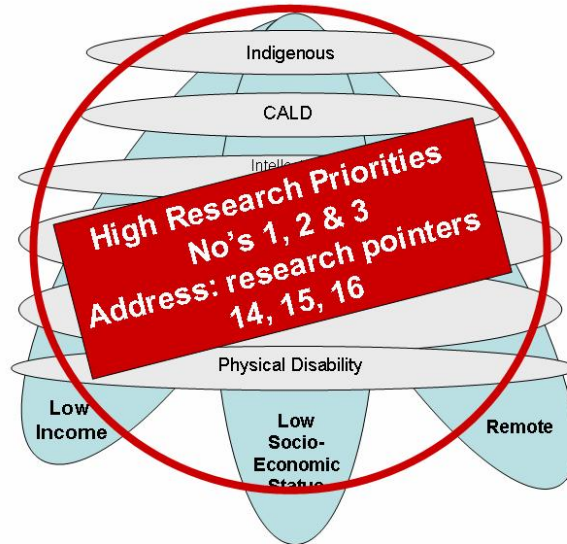
Based on the research descriptions provided in Section 5.3 it is possible to identify how the four high priority, short term research tasks satisfy the research criteria of the *Access to Medicines Consortium* described previously in Section 5.2. These links are summarised in the table below.

Table 5.3: Consortium Research Criteria met by the High Priority Research Tasks

Priority	Criteria			
	No primary stakeholder program owner	No major health program addressing the need	Multiple needs groups	Multiples stakeholders
High priority #1: re-designing aspects of the PBS and MBS safety nets to better address affordability	-	-	X	X
High priority #2: promoting enhanced medication access and management processes for complex care patients	X	X	X	X
High priority #3: medicines access – identifying the impact of macro drivers of demand – income, geography, socio-economic status	X	X	X	X
High priority #4: facilitating access to medicines by homeless people	X	X	X	X

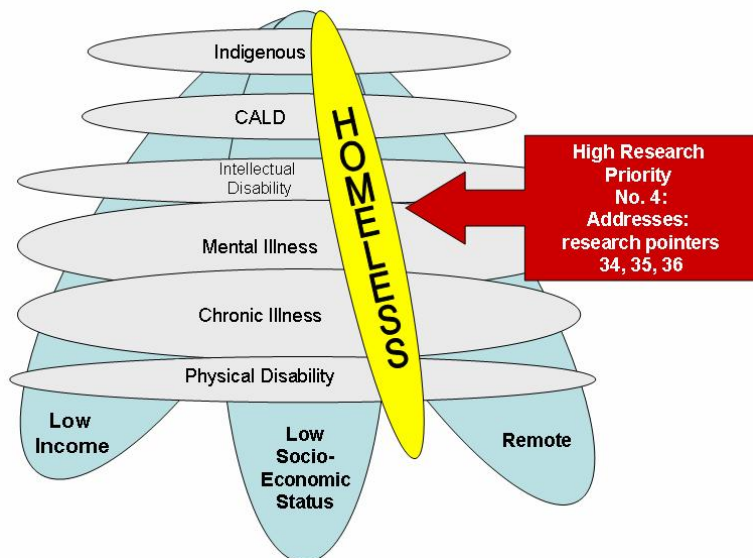
Figure 5.1 illustrates how the first three priorities are ‘big picture’ tasks addressing the needs of multiple consumer interest groups.

Figure 5.1: Relationship of High Research Priorities #1, #2 & #3 and the Future Research Pointers Identified in Consultations



The fourth high priority area relating to medication access problems experienced by the homeless is more micro in nature but still has the potential to impact on multiple consumer groups.

Figure 5.2: Relationship of High Research Priority #4 and the Future Research Pointers Identified in Consultations



5.5 CONCLUSION AND NEXT STEPS

The *Access to Medicines Consortium's* sponsorship of this project has provided a comprehensive overview of the barriers to accessing prescription medicines encountered by consumers in Australia.

The work has been based on a review of published and grey literature, and examination of routinely collected data. This highlighted the lack of strong research evidence in the area. An extensive round of telephone consultations was also conducted to examine the access issues encountered by a number of different consumer stakeholder groups. This showed there is still a broad range of consumer access problems relating to affordability, acceptability, availability and accessibility:

(1) **Affordability.** Key issues are:

- affordability of many medicines is determined decision to list/not list on the PBS/RPBS;
- some people have difficulty in establishing their identity to gain access to general or concessional patient entitlement under the PBS;
- there is often a lack of information on 'interchangeability' of branded and generic products;
- a person's illness, socio-economic status or living location can impact on earning capacity and ability to pay for prescription medicines;
- people whose medical condition(s) requires them to take a number of different, ongoing medications will spend more than those who perhaps need only one or two;
- people requiring specialist services can face significantly higher costs;
- frequency and timing of requiring medication(s) can cause cash flow problems;
- many patients face non-medication costs associated with their medical condition; and
- the quantity of free medications available through public hospitals on discharge or in outpatients of the emergency department is generally decreasing.

(2) **Accessibility:** Key issues are:

- access to specialists to prescribe medicines can be limited;
- there can be difficulties in accessing a dispensing service where community pharmacies are unavailable; and
- a patient's lack of access to transport can affect access.

(3) **Availability.** Key issues are:

- it is important for a patient to be able to access the 'best available' medications and indications through pharmacies;

- it is important for people to be able to access the most up-to-date information on effectively treating and managing their particular illness through pharmacies;
- some pharmacies do not keep stocks of certain medications, notably those stocks at the more expensive end of the scale; and
- pharmacists do not always have good communication/personal relationships with patients.

(4) **Availability.** Key issues are:

- a lack of privacy in discussing personal/sensitive medical conditions in some pharmacies;
- the need for more sensitivity by some pharmacists towards understanding and responding to the different cultural needs and expectations of different groups in society;
- a lack of involvement by some pharmacies in offering advisory and informational services;
- difficulties that some pharmacists have in providing quality one-on-one consultations with customers; and
- the need for professional development around communication skills by some pharmacists.

A number of research tasks could be pursued in response to these problems, detailed in Chapter 4. However, primary responsibility for carriage of that work rests with the Pharmacy Guild, DoHA or PBAC. The *Access to Medicines Consortium* recommends that these organisations review that list of priorities and allocate resources to further progress policy review and development in the areas identified.

The *Consortium* identified a further four high priority, short term research tasks where there is no major program addressing the needs and/or there are multiple needs groups. This makes it difficult for any single peak body stakeholder to pursue the research agenda. These priorities are:

- re-designing aspects of the PBS and MBS safety nets to better address affordability;
- promoting enhanced medication access and management processes for complex care patients;
- identifying the impact of macro drivers of demand – income, geography, socio-economic status – on access to medicines; and
- facilitating access to medicines by homeless people

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.

ATTACHMENT A: DETAILED STATISTICAL ANALYSIS

A1 NATIONAL HEALTH SURVEY

The Australian Bureau of Statistics (ABS) compiles a National Health Survey approximately every four years. The latest survey published was conducted in 2001, and published as several separate reports including an overview report (summary), Aboriginal and Torres Strait Islander results, Mental Health and Use of Medications.

The National Health Survey Summary includes demographic information such as country of birth, language spoken at home, education level, employment, region of habitation, income and socio-economic disadvantage, as well as health information such as long-term illness, medical treatments sought, type of medication used, dietary habits and weight. These data are, in general, analysed by age and sex, and occasionally demographic indicators.

A1.1 Types of treatments

The data from the National Health Survey Summary on types of treatment sought (e.g. hospital inpatient, emergency or outpatient, or consultation with a Doctor, Table A.1) indicated that:

- language spoken at home and education level do not influence the type/frequency of treatment sought;
- employment may influence the type/frequency of treatment sought, with unemployed people less likely to be a hospital inpatient or consult a doctor and non-employed people the most likely to be a hospital inpatient or consult a doctor. There were only minor differences between outpatient/emergency visits for all three employment status;
- regional location may influence the type/frequency of treatment sought, with people in major cities less likely to be a hospital inpatient than people from inner or outer regional areas, and people from outer regional areas more likely to be outpatients/emergency than people from major cities or inner regional area. There was no difference in doctor consultation;
- income may influence the type/frequency of treatment sought with people in the 1st income quintile (low income earners) more likely than people in the 5th quintile (high income earners) to be treated as an inpatient, an outpatient/emergency or consult a doctor; and
- socio-economic disadvantage may influence the type/frequency of treatment sought, with people in areas of low socio-economic status (1st quintile, highly disadvantaged) more likely to visit outpatient/emergency or consult a doctor compared to people in areas of high socio-economic status (not highly disadvantaged). There was no difference between the two quintiles for hospital inpatients.

Table A.1: Proportion of each socio-demographic category (%) by type of treatment sought⁴³.

Proportion of each socio-demographic category (%) by treatment sought			
	Hospital Inpatient	Outpatient/emergency	Doctor Consult
Main language spoken at home			
<i>English</i>	0.9	5.2	26.0
<i>Other</i>	0.8	5.2	30.6
Education			
<i>Associate diploma</i>	0.8	4.2	22.5
<i>Certificate</i>	1.1	5.4	26.2
Work force			
<i>Employed</i>	0.7	4.2	21.1
<i>Unemployed</i>	*0.2	5.4	18.6
<i>Non-employed</i>	1.5	6.8	36.2
Location			
<i>Major City</i>	0.7	4.5	25.7
<i>Inner regional</i>	1.2	4.5	23.7
<i>Outer regional</i>	1.0	6.0	19.1
Income			
<i>1st quintile (Low)</i>	1.0	6.4	30.4
<i>5th quintile (High)</i>	0.5	3.4	19.4
Socio-economic disadvantage			
<i>1st quintile (Low)</i>	0.9	5.5	28.9
<i>5th quintile (High)</i>	0.8	3.9	22.4

*data with high variability and should therefore be used with caution.

Comparison of doctor versus chemist consultations by age group (Table A.2) indicated that most people consulted a doctor or chemist in the 15-64 years age group. While doctor consultations remained fairly constant over this time period, younger people (15-44 years) were more likely to consult a chemist, with proportions diminishing after 45 years of age. Surprisingly relatively few elderly people (3.7%, 75 years or more) consulted a chemist, with a fraction more inclined to consult a doctor (9.6%).

⁴³ Adapted from the National Health Survey: Summary, Australia. 2001.

Table A.2: Proportion of doctor or chemist consultations (%) by age group of total population

Proportion of doctor/chemist consultations (%) by age group of total population		
Age Group	Doctor Consult	Chemist Consult
0-4	6.9	9.8
5-14	8.5	7.8
15-24	10.4	18.0
25-34	13.1	19.5
35-44	13.7	15.0
45-54	14.4	12.6
55-64	12.4	9.2
65-74	11.1	4.4
75+	9.6	3.7
Total	100.0	100.0

A1.2 Use of Medication

The 1995 use of medication survey collected information on types of medications used for illness classified as a ‘National Health Priority’. In this report, 59.1% of the total Australian population reported using medications of some sort (not including vitamins and herbal products). The majority of medications used were pain relievers (23.6% of population), medications for heart problems (10.6% of population) and skin ointments (9.8%). For medications for other chronic illnesses, 6.1% of the population used asthma medication, 2.6% used arthritis medication and 1.1% used medication for diabetes.

The data for ages 15-64 years (normal working age range) showed minor variations of medication use for people of different employment status (Table A.3) as follows:

- non-employed people were more likely than employed or unemployed people to use medication for arthritis, heart problems, sleeping medications and medications for anxiety, tension or depression;
- employed people were more likely than unemployed or non-employed people to use skin ointments; and
- employed people were less likely than unemployed or non-employed people to use medications for asthma.

Table A.3: Proportion of each employment group (%) by type of medication used for ages 15-64 years⁴⁴.

Type of Medication	Proportion of each employment group (%) by type of medication used			
	Employed	Unemployed	Non-Employed	Total
Medication for Diabetes	0.7	1.6	2.0	1.1
Asthma Medication	5.5	7.2	7.5	6.1
Medication for Arthritis	1.8	1.3	4.9	2.6
Medication for Coughs/Colds	6.6	5.6	6.1	6.4
Skin Ointments	11.3	9.9	9.8	10.8
Stomach Medications	3.2	3.5	5.0	3.7
Laxatives	0.3	*0.2	0.6	0.4
Medication for Allergies	3.9	3.5	3.4	3.8
Diuretics	0.6	0.5	2.3	1.0
Medication for Heart Problems/Blood Pressure	5.4	4.0	12.0	7.0
Medications to Lower Cholesterol	1.2	0.9	2.2	1.4
Pain Relievers	27.7	24.9	27.4	27.5
Tranquillisers and sleeping medications	2.4	3.2	7.0	3.6
Other	16.0	15.2	21.5	17.4
Total	58.5	55.4	64.5	59.9

**data with high variability and should therefore be used with caution.*

Analysis by country of origin indicated that there are variations in medication uses across these groups (Table A.4) as follows:

- people in Australia from European backgrounds were more likely to use medications for diabetes compared to the total population;
- people originating from the Middle East, Asia and Europe were less likely to use asthma medications compared to the total population;
- people originating from Australia, New Zealand and the UK and Ireland were more likely to use skin ointments compared to the total population;
- people originating from Europe and the Middle East were more likely to use stomach medications compared to the total population;
- people originating from the Middle East and Asia were less likely to use diuretics compared to the total population;
- people originating from the UK and Ireland and Europe were more likely to use medications for heart problems or blood pressure, and people originating from the Middle East and Asia were less likely to use medications for heart problems or blood pressure compared to the total population;
- people originating from Europe were more likely to use medications to lower cholesterol compared to the total population;
- people originating from Europe were more likely to use medications for anxiety, tension or depression, and people originating from Asia were less likely to use medications for anxiety, tension or depression compared to the total population; and

⁴⁴ Adapted from the National Health Survey: Use of Medications, Australia. 1995.

- there was no major difference between country of origin and use of medications for arthritis, coughs and colds, laxatives, allergies, pain relievers, sleeping medications or tranquillisers.

Table A.4: Proportion of Country of Origin Category (%) by type of Medication Use⁴⁵.

Type of Medication	Proportion of country of origin (%) by type of medication used							Population Total
	Australia **	NZ and other Oceania **	UK and Ireland **	Other Europe **	Middle East **	Asia **	All other Countries **	
Medication for Diabetes	1.1	1.8	2.0	4.2	2.4	1.2	2.6	1.4
Asthma Medication	7.2	5.0	6.7	3.4	2.0	2.6	7.4	6.6
Medication for Arthritis	3.4	2.4	4.9	4.8	*1.2	0.7	4.5	3.4
Medication for Coughs/Colds	0.6	5.0	5.3	4.2	4.7	6.8	5.2	7.1
Skin Ointments	10.0	11.0	12.1	6.1	4.5	7.6	7.8	9.8
Stomach Medications	3.7	4.0	5.0	7.0	7.1	3.6	3.9	4.0
Laxatives	0.5	*0.6	0.6	0.5	*0.6	0.5	0.7	0.5
Medication for Allergies	3.2	3.7	3.4	2.2	3.1	2.9	5.3	3.2
Diuretics	2.1	2.1	3.5	3.7	*0.6	0.3	1.5	2.2
Medication for Heart Problems/Blood Pressure	9.8	7.5	15.7	18.6	5.2	5.8	10.8	10.5
Medications to Lower Cholesterol	1.5	0.8	2.6	3.9	2.7	1.0	2.1	1.7
Pain Relievers	23.6	27.0	27.4	23.3	23.4	16.4	23.1	23.6
Tranquillisers and sleeping medications	3.5	4.1	5.1	5.9	3.5	1.6	4.7	3.7
Other	17.7	17.2	23.7	17.5	10.7	11.6	19.5	17.8
Total	58.8	58.4	68.8	62.2	48.4	45.0	60.1	59.1

*data with low confidence intervals and should be used with caution.

**78% of the population are from an Australian background, 2% from NZ and other Oceania, 6.7% from the UK and Ireland, 6.3% from Europe, 0.8% from the Middle East, 4.1% from Asia, and 1.8% from all other countries.

Whether these variations are due to varying rates of specific diseases/illness in people from different countries of origin, or are due to actual barriers to medicine access was not discussed. When reviewing the following information it is important to remember that 78% of the population is represented by people of Australian decent, which will skew the total population data.

With regards to prescribed medications, there were variations in the proportion of people using medication with or without advice (or prescription) which seemed to be large dependent on the type of medication, as follows:

⁴⁵ Adapted from the National Health Survey: Use of Medications, Australia. 1995.

- 34.9% of people using analgesic medication (e.g. aspirin, paracetamol, opioids etc) were medically advised to do so (15.4% had the medication prescribed);
- most people using opioids (95.8%) were medically advised to do so (64.2% had the medication prescribed);
- 55.0% of people using aspirin were medically advised to do so (21.1% had the medication prescribed); and
- 21.9% of people using paracetamol were medically advised to do so (7.2% had the medication prescribed).

The low proportion of people advised to use aspirin or paracetamol is probably not surprising since the majority of people taking aspirin (30.1%) and paracetamol (57.1%) were using it for headaches. For people using opioids however, the majority were taking them for musculoskeletal problems (27.1%) or respiratory conditions (10.2%).

The majority of people using psycholeptic (60.1%) and/or anti-depressant drugs (53.3%) were using anti-depressant drugs were medically advised to do so, as follows:

- 99.3% of people using anti-depressants were medically advised to do so (98.5% being prescribed);
- the majority of people used anti-depressants for “all mental disorders” (70.2%) followed by depression (37.9%) and tension and nervousness (22.7%);
- 98.5% of people using psycholeptic drugs were medically advised to do so (96.7% being prescribed); and
- psycholeptic drugs were used mainly for “all mental disorders” (43.3%) and insomnia (38.0%) followed by tension and nervousness (27.0%).

A1.3 Chronic Illness

Long term conditions (or chronic illness) was defined in the National Health Survey (2001) as a condition which was current at the time of the survey and which, in the respondent's opinion, had lasted for six months or more, or which he or she expected would last for six months or more. Some conditions reported were assumed to be long-term conditions: these included asthma, cancer, diabetes insipidus, and diabetes mellitus types 1 and 2, rheumatic heart disease, heart attack and stroke.

Analysis of chronic or long term illness indicated that there may be variations in chronic illness incidence depending on a persons' socio-demographic status (Table A.5) as follows:

- more people who speak English at home than those who do not reported having asthma and malignant neoplasms;
- non-employed people showed generally higher rates of disease/illness than employed or unemployed people (cause or effect was not established), whereas employed and unemployed people showed similar rates of disease/illness;
- people with lower incomes (1st quintile) reported higher rates of arthritis and disease of the eye and adnexa than people with high incomes (5th quintile); and

- people from low socio-economic areas (1st quintile) generally showed non-significant higher rates of disease/illness than those in higher socio-economic areas (5th quintile), especially for diabetes.

Table A.5: Proportion of each socio-demographic category (%) by type of Illness⁴⁶.

Proportion of each socio-demographic category (%) by type of Illness							
	Asthma	Diabetes	Malignant Neoplasms	Circulatory System Disease	Arthritis	Eye and Adnexa	Ear and Mastoid
Total Population	11.6	2.9	1.7	17.3	13.6	43.1	10.7
Main language spoken at home							
English	11.8	3.6	2.0	22.7	18.6	64.4	17.5
Other	6.0	5.1	0.8	18.1	15.2	63.2	13.2
Work force							
Employed	11.0	1.8	1.0	13.4	9.9	55.1	12.5
Unemployed	14.0	2.0*	0.5*	9.7	8.3	45.3	11.0
Non-Employed	11.0	7.1	3.1	35.6	31.2	76.7	23.0
Location							
Major City	11.7	3.0	1.3	16.0	12.7	51.1	12.7
Inner Regional	11.3	2.8	1.6	18.9	16.0	52.4	15.9
Outer Regional/Other	11.6	2.9	1.4	17.6	14.5	50.4	15.9
Income							
Low (1st quintile)	12.3	5.5	2.1	25.4	22.8	60.1	17.9
High (5th quintile)	10.7	1.3	0.8	10.8	6.8	47.8	10.2
Index of socio-economic disadvantage							
Low (1st quintile)	12.1	4.2	1.2	21.0	17.5	52.2	15.1
High (5th quintile)	11.2	1.9	1.1	14.7	11.0	54.4	11.6

*data with high variability and should therefore be used with caution.

⁴⁶ Adapted from the National Health Survey: Summary, Australia. 2001.

Two of the most common chronic illnesses were asthma (11.6% of the population) and diabetes (or high blood sugar levels, 3.2% of the population). Further analysis of these two illnesses showed that:

- 39.8% of asthma sufferers took no action for the illness;
- 58.8% of asthma sufferers used pharmaceutical medication (8.1% preventative, 16.9% relief and 33.8% for both prevention and relief);
- 8.5% of asthma sufferers consulted a doctor;
- 1.1% of asthma sufferers were admitted to hospital or visited outpatients;
- 7.3% of people with diabetes took no action for their illness;
- 79.8% of people with diabetes changed their diet and eating plan;
- 30% of people with diabetes exercised most days; and
- 69.7% of people with diabetes used pharmaceutical medication (19.1% using insulin, 55.9% using other types).

Compared to data from the 1995 National Health Survey, most rates of long term/chronic conditions remained constant, with a few notable exceptions e.g. epilepsy (1.3% of the population in 1995 and 6.2% in 2001) and back pain/problems (4.9% in 1995 and 20.8% in 2001).

A1.4 Mental Health.

The long-term mental and behavioural problems included in the 2001 National Health Survey were:

- organic mental problems- grouped together on the basis of a common aetiology in cerebral disease, brain injury, or other insult leading to cerebral dysfunction for example dementia and delirium;
- alcohol and drug problems- the use of one or more psychoactive substances, which may or may not have been medically prescribed, e.g. alcohol, tobacco, sedatives and hallucinogens;
- mood (affective) disorders-a change in mood or affect to depression or to elation with or without associated anxiety, e.g. depression, mania or bipolar;
- anxiety related problems-exists in association with psychological stress for example, feelings of anxiousness and nervousness;
- problems of psychological development-impairment or delay in the development of functions that are strongly related to biological maturation of the central nervous system;
- behavioural and emotional problems with usual onset in childhood/adolescence-lack of persistence in activities that require cognitive involvement and a tendency to move from one activity to another without completing any one, together with disorganised, ill regulated and excessive activity;
- other mental and behavioural problems; and
- symptoms and signs involving cognitions, perceptions, emotional state and behaviour.

In the National Health Survey (2001), psychological distress was defined from the Kessler Psychological Distress Scale 10 items (K10), which reflects non-specific psychological distress based on 10 questions about negative emotional states in the four

weeks prior to interview. The K10 was scored as low (10-15), moderate (16-21), high (22-29) or very high (30-50). Based on research from other population studies, a very high level of psychological distress, as shown by the K10, may indicate a need for professional help.

Approximately 1.8 million people (9.6% of the total population) reported having (or had) long term mental or behavioural problems in 2001. These were most likely to have been anxiety or mood related problems (4.5% each). Mental Health can be divided into two categories Mental and Behavioural Problems and Psychological Distress, each is discussed individually below.

When considering cultural and language differences (Table A.6), the data indicated that the proportion of people with mental and behavioural problems and/or high-very high psychological distress was similar for people born in Australia or overseas. People who spoke English at home, however, had a higher rate of mental or behavioural problems than those who did not, and people who did not speak English at home had higher rates of high-very high psychological distress compared to those who spoke English.

Table A.6: Proportion of Cultural and Language Background Category (%) by Mental Illness⁴⁷.

Proportion of cultural and language background category (%) by mental illness		
	Mental and behavioural problems	Psychological distress (very high)
Country of Origin		
<i>Australia</i>	9.8	3.4
<i>Other</i>	9.0	4.2
Main language spoken at home		
<i>English</i>	10.6	3.2
<i>Other</i>	9.6	5.5

Analysis of education and employment (Table A.7) indicated variation in mental health across socio-demographic ranges as follows:

- people without post-school qualifications had a higher rate of mental and behavioural problems and high-very high psychological distress than those with qualifications;
- mental and behavioural and psychological problems are higher amongst unemployed or non-employed people compared to employed people; and
- people from disadvantaged socioeconomic areas (lowest on SEIFA scale, 1st quintile) were more likely to have mental and behavioural problems or high-very high levels of psychological distress than people in less disadvantaged areas (highest on the SEIFA scale, 5th quintile). A similar trend was seen for high-very high.

⁴⁷ Adapted from the National Health Survey: Mental Health, Australia. 2001.

Table A.7: Proportion of Education and Employment category (%) by Mental Illness⁴⁸.

	Proportion of education and employment category (%) by mental illness	
	Mental and behavioural problems	Psychological distress (very high)
Education		
<i>Post-school qualification</i>	9.3	2.4
<i>No post school qualification</i>	11.2	4.7
<i>Not stated</i>	19.3	5.7
Work force		
<i>Employed</i>	8.4	1.9
<i>Unemployed</i>	14.7	9.8
<i>Non-Employed</i>	14	6.4
Income		
<i>1st quintile (Low)</i>	12.3	7.0
<i>5th quintile</i>	8.1	2.1

Consideration of co-morbidities (Table A.8) of people with mental health problems indicated that people with mental and behavioural problems showed higher prevalence rates of diseases of musculoskeletal system and connective tissue, diseases of the circulatory system, Asthma, injury event and psychological distress compared with the people without mental and behavioural problems. Similarly, people with very high psychological distress indicated higher rates of diabetes, disease of the circulatory system, asthma, malignant neoplasms and injury event.

Table A.8 Proportion of Mental Illness (%) by of Co-Morbidity Illness category⁴⁹.

	Proportion of mental illness (%) by of co-morbidity illness category			
	Mental and behavioural problems	Without Mental and behavioural problems	Psychological distress (very high)	Without Psychological distress (very high)
Asthma	17.0	11.0	6.4	3.2
circulatory system	21.2	16.4	4.8	3.3
Diabetes	3.6	2.9	6.4	3.5
musculoskeletal system	47.7	30.4	5.1	2.5
Injury	16.8	11.7	5.7	3.3
Psychological distress	19.6	1.7	-	-

Assessment of the types of actions taken by people with mental illness (Table A.9) indicated that:

⁴⁸ Adapted from the National Health Survey: Mental Health, Australia. 2001.

⁴⁹ Adapted from the National Health Survey: Mental Health, Australia. 2001.

- people with mental or behavioural problems were 1.5 times or more likely to visit a hospital or consult a doctor or other health professional than people without mental or behavioural problems; and
- people with very high psychological distress were 2 times or more likely to visit a hospital or consult a doctor or other health professional than the national population.

Table A.9: Proportion of Mental illness (%) by Actions Taken⁵⁰.

Proportion of mental illness(%) by actions taken				
	Mental and behavioural problems	Without Mental and behavioural problems	Psychological distress (very high)	Population total
Hospital visit**	8.3	4.7	15.3	5.1
Hospital Admission** (>3 times)	2	0.8	4.8	0.9
Consult Doctor	38.6	23	53.2	24.5
Consult Other Health Professional	29.2	17.1	37.1	18.3

**action taken in the two weeks prior to survey*

***includes inpatients, outpatients and emergency*

Analysis of the types of medications used by people with Mental Health problems (Table A.10) indicates that:

- people with mental or behavioural or psychological problems use substantially higher amounts of mental health medications than people without mental or behavioural problems or the national population, with the majority of people using anti-depressants; and
- almost half of the population with mental or behavioural problems or psychological did not use any medication.

Table A.10 Proportion of Mental illness (%) by Medications Used⁵¹.

Proportion of mental illness (%) by medications used				
	Mental and behavioural problems	Without Mental and behavioural problems	Psychological distress (very high)	Population Total
Sleeping Tablets	10	3.4	16.8	4.1
Anxiety Tablets	8.7	1.1	13.6	1.9
Tranquillisers	3.2	0.4	5.6	0.7
Anti-depressants	24.9	2.3	28.8	4.7
Mood Stabilisers	2.6	0.3	4.1	0.6
Other Mental Health Medication	2.3	0.1	*2.9	0.4
No Medication	49.5	85.7	46.3	81.9

⁵⁰ Adapted from the National Health Survey: Mental Health, Australia. 2001

⁵¹ Adapted from the National Health Survey: Mental Health, Australia. 2001

A1.5 Indigenous Background.

In the National Health Survey (2001), People of Indigenous background refers to people who identified themselves, or were identified by another household member, as being of Aboriginal and/or Torres Strait Islander origin.

The Indigenous population was considerably younger than the non-Indigenous population (majority of Indigenous population in the 5-14 years age group compared to the majority of the non-Indigenous population in the 55 plus age group), therefore the results have been “age-adjusted” for comparison to national data.

Analysis of the data collected for Indigenous Australians indicated that one third of Indigenous Australians reported their general health as ‘fair or poor’, almost twice the rate of non-Indigenous Australians (34% compared with 18%, respectively, Table A.11), however both Indigenous and non-Indigenous Australians were equally likely to report having at least one long term health condition (78% each).

Comparison of Indigenous Australians living in remote or non-remote areas (Table A.11) indicated that:

- Indigenous Australians living in non-remote areas were more likely to report having long term health conditions; and
- the major long term health conditions reported for both remote and non-remote areas were eye sight problems, circulatory problems and asthma (16%).

Comparison of Indigenous to non-Indigenous Australians with regards to long term health problems (Table A.11) indicated that:

- Indigenous Australians were more likely to report asthma as a long term health condition than non-Indigenous Australians;
- 11% of Indigenous Australians report diabetes as a health condition, over three times the amount of non-Indigenous Australians; and
- diabetes was twice as likely amongst Indigenous Australians from remote (16%) compared to non-remote areas (9%).

Comparison of Indigenous to non-Indigenous Australians with regards to health actions taken (Table A.11) indicated that:

- Indigenous Australians were more likely to have taken a health related action than non-Indigenous Australians;
- Indigenous Australians were twice as likely to have been admitted to hospital or visited an emergency or outpatients department than non-Indigenous Australians;
- there was no significant between consultations with doctors between Indigenous and non-Indigenous Australians;
- Indigenous Australians were more likely to see a nurse or Aboriginal Health worker than non-Indigenous Australians; and
- both Indigenous and non-Indigenous Australians were equally likely to report having seen a Chemist (4% each), but Indigenous Australians living in remote areas were less

likely than Indigenous Australians living in non-remote areas to see a chemist (0% compared with 5%, respectively).

Table A.11: Proportion of Indigenous (by remoteness) and non-Indigenous Australians (%) by health status, chronic illness and health action taken⁵².

Proportion of Indigenous (by remoteness) and non-Indigenous Australians (%) by health category					
	Indigenous			Non-Indigenous	All persons
	Remote	Non-Remote	Total	Total	Total
Self assessed health status					
<i>Excellent/very good</i>	28.0	36.0	34.0	52.0	52.0
Good	43.0	28.0	32.0	30.0	30.0
Fair/Poor	28.0	35.0	34.0	18.0	18.0
Chronic Illness					
<i>Neoplasms/Cancer</i>	*1.0	*1.0	*1.0	2.0	2.0
Diabetes	16.0	9.0	11.0	3.0	3.0
Eye/sight problems	38.0	49.0	46.0	51.0	51.0
<i>Circulatory problems</i>	24.0	18.0	19.0	17.0	17.0
Asthma	15.0	18.0	17.0	12.0	12.0
Actions taken					
Hospital admission	21.0	19.0	20.0	12.0	12.0
Emergency/outpatients	9.0	5.0	6.0	3.0	3.0
<i>Consult Doctor</i>	24.0	27.0	27.0	24.0	24.0
<i>Consult Other Health Professional</i>	7.0	5.0	5.0	6.0	6.0
Other Health Professional					
Aboriginal Health Worker	13.0	4.0	6.0	np	
Nurse	17.0	1.0	5.0	1.0	
Chemist	0.0	5.0	4.0	4.0	
Social worker/welfare officer	0.0	*2.0	*1.0	0.0	
Other	*1.0	6.0	5.0	8.0	

*data with high variability and should therefore be used with caution.

** no significant difference across categories where the conditions are shown in italics

A1.6 Conclusion from examination of National Health Survey data.

There is some 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;

⁵² Adapted from the National Health Survey: Aboriginal and Torres Strait Islander Results, Australia. 2001.

- 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.

Useful information that was not published in the 2001 National Health Survey would be:

- types and use of medication for people with chronic illness; and
- detailed use of Other Health Professionals (OHP), in particular pharmacists, for all people with (and without) chronic or mental illness and across socio-demographic status. This information can currently be obtained from the ABS upon request as a 'fee for service' product.

A2 NATIONAL HEALTH STRATEGY, RESEARCH PAPER NO. 1

The National Health Strategy published a paper in 1992 ('Enough to make you sick: How income and environment affect health')⁵³ 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 hospitals, outpatient clinics and doctor visits) and less use of preventative and dental services. People from socio-economic disadvantaged areas (or low income earners) were significantly more likely to visit outpatients (adults and children), less likely to visit the dentist (women and children) and reported over 10% fewer encounters with preventative services such as mammography screening, pap smears and rubella immunisation (women) compared to people of higher socio-economic status⁵⁴. Low income earning males also showed a 71% greater incidence of hospital admission.

People from low socio-economic backgrounds also showed a higher death rate compared to people from high socio-economic backgrounds. Adults of low socio-economic status showed higher death rates from certain respiratory disorders, lung cancer, certain circulatory disorders, car accidents, suicide and diabetes. It should also be noted

⁵³ Mathers, C. Enough to make you sick: how income and environment affect health. Research paper No. 1, National Health Strategy, 1992.

⁵⁴ Ibid.

however, that people of low socio-economic status also show higher incidence of smoking, obesity and in-activity, which may related directly to their health conditions. Children of low socio-economic status showed higher death rates from hypoxia, sudden infant death syndrome, accidental drowning (boys), disorders related to short gestation (girls) and car accidents (girls). People from low socio-economic backgrounds are also the most likely to suffer a disability, have a serious chronic illness, have a recent illness or report their health as fair/poor. With respect to chronic illness and disability however, cause or effect was not examined.

These data are consistent with more recent findings from the National Health Survey and indicate that low income is a barrier to accessing certain types of medicine, especially preventative services. The higher incidence of hospital admissions and death from people with low incomes also suggests that there are barriers to accessing medicines for these people.

A3 DISABILITY, AGEING AND CARERS SURVEY

The Survey of Disability, Ageing and Carers (SDAC, ABS 2003) defined disability as any limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities. Examples range from hearing loss which requires the use of a hearing aid, to difficulty dressing due to arthritis, to advanced dementia requiring constant help and supervision.

The SDAC 2003 reported one in five people in Australia (3,958,300 or 20.0%) had a reported disability. This rate was much the same for males (19.8%) and females (20.1%). After removing the effects of different age structures there was little change in the disability rate between 1998 (20.1%) and 2003 (20.0%). The rate of profound or severe core-activity limitation also showed little change between 1998 (6.4%) and 2003 (6.3%).

The disability rate did increase with age, however, reaching 92% for those aged 90 years and over. The prevalence of profound or severe core-activity limitation gradually increased from 3% for age groups 0-4 years through to 10% for 65-69 years and then increased sharply to 74% for those aged 90 years and over. This contrasted with the overall disability rate which increased steadily from 4% of 0-4 year olds to 41% of 65-69 year olds and 92% of those aged 90 years and over. Taking this into account, the following data from the SDAC report (2003) is for persons aged 15-64 years only.

Analysis of reported disabilities and/or core-activity limitations (Table A.12) indicated that:

- people with a disability are more likely to have limited education (school only) and less likely to have a Bachelor Degree than people without a disability;
- almost 5 times the proportion of people with a disability compared to those without are non-employed;
- people with a disability are two thirds less likely to be employed compared to people without a disability;

- the majority of disabled people are in low income quintiles compared to the majority of non-disabled people being in high income quintiles;
- the median gross weekly income for disabled people is approximately half that of non-disabled people (\$255 compared with \$501, respectively); and
- there was no major difference in geographic location of disabled and non-disabled people with the majority living in major cities.

Table A.12: Proportion of Disability populations (%) by socio-demographic status for ages 15-64 years⁵⁵.

Proportion of disability populations (%) by socio-demographic status			
	All with reported disability	No reported disability	Population Total
Total	20.0	80.0	100.0
Education			
Bachelor degree	12.7	19.7	18.5
Diploma	6.8	8.4	8.1
Certificate	26.0	23.3	23.7
School	53.9	48.2	49.1
Unknown	0.7	0.5	0.5
Total	100.0	100.0	100.0
Work force			
Employed	48.7	76.5	71.9
Unemployed	4.6	4.0	4.1
Non-employed	46.8	9.4	24.0
Total	100.0	100.0	100.0
Location			
Major Cities	62.0	68.3	67.2
Inner regional	23.8	20.4	21.0
Other	14.2	11.3	11.8
Total	100.0	100.0	100.0
Equivalised gross household income quintiles **			
Lowest	24.2	9.6	12.1
Highest	11.8	21.3	19.7
Median gross/week (\$)	255.0	501.0	479.0

**based on total population in private dwellings.*

⁵⁵ Adapted from the Disability, Aging and Carers Survey (SDAC): Summary of Findings, Australia, 2003.

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.

Other useful information not published in SDAC (2003) would be:

- data about the use of medication or types of treatments sought for people with disabilities.

A4 HOUSEHOLD EXPENDITURE SURVEY (HES)

The 1998–99 Household Expenditure Survey (HES) collected detailed information about the expenditure, income and household characteristics of a sample of 6,893 households resident in private dwellings throughout Australia. HES results have been used for many applications including updating the weighting pattern of the Consumer Price Index, conducting standard of living studies, evaluating government policy and market research.

Analysis of HES data (Table A.13) showed that:

- on average, Australians spend 4.6% of their weekly goods and services expenditure on medical care and health expenses, compared to 13.9% for housing costs, 18.2% for food, 16.9% for transport and 12.7% for recreation;
- low income earners spend proportionally more on medical and health care expenses, housing and food than high income earners;
- unemployed people spent (proportionally) much less on medical and health expenses than employed or non-employed people. Unemployed people also spent proportionally less on recreation, but more on housing than employed or non-employed;
- non-employed people spend the most on Medical and Health care expenses compared to employed and unemployed people;
- people in rural areas spend proportionally more on medical and health expenses, food and transport, but less on housing than people in cities or urban areas;
- people in urban (not Capitol Cities) spent the least on Medical and Health care expenses;
- couples without children spent proportionally more on medical and health care expenses than families with children;
- of families with children, couples with two children spent more than couples with one child on medical expenses. Couples with three or more children, however, spent less on medical and health care expenses, and more on food expenses; and
- people who originated in Italy or Vietnam had less medical and health care expenditure than people originating from other countries. People originating from the Netherlands spent proportionally the most on medical and health care expenses, 1.5 times the national total.

Table A.13: Proportion of Household expenditure (including Medical and Health Care Expenditure) (%) by socio-demographic status⁵⁶.

Proportion of household expenditure (%) by socio-demographic status							
	Medical care and Health expenses	Housing costs	Food	Transport	Recreation	Other	Total
Total (Australia)	4.6	13.9	18.2	16.9	12.7	33.7	100
Income							
<i>1st quintile (Low)</i>	5.0	16.0	19.6	15.0	10.8	33.6	100
<i>5th quintile (High)</i>	4.5	12.0	16.6	17.8	14.1	35.0	100
Employment							
<i>Employed</i>	4.6	13.0	18.1	16.8	12.6	34.9	100
<i>Unemployed</i>	1.9	20.4	18.0	15.6	9.6	34.5	100
<i>Non-employed</i>	5.7	13.4	20.5	15.1	13.1	32.2	100
Location							
<i>Capitol City</i>	4.7	14.4	18.0	16.5	12.8	33.6	100
<i>Other Urban</i>	4.4	14.4	18.1	16.4	12.5	34.2	100
<i>Rural</i>	4.9	9.3	19.6	20.7	12.3	33.2	100
Children							
<i>Couple only</i>	5.7	13.1	17.8	16.9	13.6	32.9	100
<i>1 child</i>	4.2	15.3	17.3	17.0	11.8	34.4	100
<i>2 children</i>	4.5	13.4	18.8	17.2	12.3	33.8	100
<i>3 or more children</i>	4.1	14.4	20.5	13.3	13.2	34.5	100
Country of Origin							
<i>Australia</i>	4.7	13.7	18.0	17.2	12.9	33.5	100
<i>NZ</i>	3.0	18.4	17.4	16.3	11.1	33.8	100
<i>UK and Ireland</i>	4.8	13.8	17.5	15.2	14.1	34.6	100
<i>Italy</i>	3.0	18.4	17.4	16.3	11.1	33.8	100
<i>Germany</i>	4.9	16.5	18.5	14.3	13.0	32.8	100
<i>Greece</i>	4.2	12.6	26.4	13.4	9.5	33.9	100
<i>Viet Nam</i>	2.9	16.7	24.1	18.4	10.4	27.5	100
<i>Netherlands</i>	7.0	10.8	19.1	17.5	11.6	34.0	100
<i>Other</i>	4.2	14.9	18.6	16.9	11.6	33.8	100

⁵⁶ Household Expenditure Survey (HES), Australia, 1998-1999.

Consideration of practitioner's fees and expenditure on medical and pharmaceutical products (Table A.14) showed that people in the 5th income quintile (high income earners) generally spent less on practitioner's fees and medical/pharmaceutical products than lower income earners. On average, people in the 1st income quintile spent the highest proportion of their weekly income on practitioner's fees and medical/pharmaceutical products.

Table A.14: Proportion of average weekly income spent (by income quintile, %) on medical expenses.

	Proportion of income spent (by income quintile, %) on medical expenses					
	1st quintile	2nd quintile	3rd quintile	4th quintile	5th quintile	total population
Ave weekly income	100.0	100.0	100.0	100.0	100.0	100.0
Practitioner fees						
<i>GP fee</i>	0.2	0.1	0.1	0.1	0.1	0.1
<i>Specialist fee</i>	0.5	0.4	0.4	0.3	0.2	0.3
<i>Dental fee</i>	1.0	0.7	0.6	0.5	0.4	0.5
<i>Opticians fee</i>	0.5	0.2	0.1	0.1	0.1	0.1
<i>Physiotherapist fee</i>	0.1	0.2	0.1	0.1	0.1	0.1
<i>Total</i>	2.4	1.6	1.3	1.1	0.9	1.1
Medicines and pharmaceutical products						
<i>medicines and pharmaceutical products</i>	0.3	0.1	0.1	0.1	0.0	0.1
<i>prescriptions</i>	1.4	0.7	0.4	0.3	0.2	0.3
<i>non-pres pain relievers</i>	0.2	0.1	0.1	0.1	0.0	0.1
<i>non-pres ointments</i>	0.3	0.1	0.1	0.1	0.1	0.1
<i>Necessary medicines and pharmaceutical products</i>	1.1	0.6	0.3	0.3	0.2	0.3
<i>surgical dressings</i>	0.1	0.0	0.0	0.0	0.0	0.0
<i>Total</i>	3.6	1.9	1.0	0.9	0.5	0.9

There is evidence from HES that:

- lower income earners and couples without children spend more on medical and health care expenses than the average Australian
- couples with 3 or more children may sacrifice medical expenditure on food costs; and
- cultural background may influence medical and health care expenditure.

Other useful information not published in HES would be:

- breakdown of practitioners fees and expenditure on medical and pharmaceutical products by socio-demographic indices such as country of origin, employment status, location and number of children.

A5 HOSPITAL MORBIDITY DATA ANALYSIS: REPORT FROM TRCMM

A5.1 Introduction

Healthcare Management Advisors (HMA) has provided TRC Mathematical Modelling (TRCMM) with data concerning so-called “standard rates” that have been computed for various medical conditions, broken down by socio-economic and regional categories. TRCMM has been informed that the standard rates are averages of “scores” assigned to each person in each socio-economic / regional category pair. The number of data included in the calculation of the standard rates has been provided to TRCMM, but not the original data itself.

HMA has instructed TRC Mathematical Modelling to assume that the populations within each socio-economic group / region pair are Poisson distributed with regard to the scores assigned to each person.

HMA wishes to know if there is any significant difference between the standard rates computed within the datasets corresponding to certain health issues, or PPH Categories, and whether the sample sizes are large enough for meaningful statistical analysis.

The data provided correspond to average standard rates for different ASGC remoteness categories and SEIFA deciles. As an example, Table A.15 shows the average rates for the Ear, Nose and Throat PPH category whilst Table A.16 shows the sample sizes used in the Ear, Nose and Throat PPH category. As instructed, it has been assumed that the populations within *each* socio-economic group / region pair are Poisson distributed with regard to the "scores" assigned to each person. This is a crucial assumption as it used to determine the variance of this average rate, which is of great importance when determining whether different means are statistically different.

Table A.15 : Average rates for the Ear, Nose and Throat category.

SEIFA Deciles	Remoteness Categories			
	0	1	2	3
1	156.9541	203.9013	240.043	343.8007
2	204.3597	177.5396	292.0641	364.3141
3	177.1246	194.4152	235.2844	477.6629
4	148.1736	181.1955	205.7308	452.1309
5	144.4896	153.1951	228.8183	408.9434
6	175.1585	151.6368	146.7866	375.137
7	143.6807	145.8183	202.2215	212.3827
8	141.9409	236.933	149.327	381.1906
9	126.4004	130.6215	116.757	215.5499
10	115.2399	52.62095	70.85321	

Table A.16 : Number of values for the Ear, Nose and Throat category.

SEIFA Deciles	Remoteness Categories			
	0	1	2	3
1	1102	1181	1204	506
2	1460	1303	1451	289
3	1733	1178	751	482
4	1265	1326	607	146
5	2215	757	183	99
6	2445	642	140	288
7	2115	324	306	86
8	2341	415	92	191
9	2128	98	47	36
10	2013	10	5	

A5.2 Analysis of Results

The analysis performed is to determine whether the standard rates for each socio-economic group / region pair are significantly different. The null model that we will investigate is that the SEIFA deciles and remoteness categories are not significant in determining the average standard rates. To investigate the null hypothesis we shall look at a generalised log-linear model. This model applies a Poisson log-linear model to the observed cell totals with an offset term included to allow for the different number of scores in each cell. The null deviance of the fitted model is an indication of how far the fitted model is away from the null model. If this deviance is relatively high then we should reject the null hypothesis since the model using the decile and category data has achieved a much better result than if these were not present. The p-value is a measure is the level at which we should reject the null hypothesis, so that a p-value of 0.05 indicates that the null hypothesis should be rejected at the 95% level.

Table A.17: The results of the statistical analysis

PPH Category	Null Deviance	Degrees of Freedom	P - value
Ear nose and throat infections	90034.06	38	0
All separations - not PPHs	761657914	38	0
Angina	102232.4	38	0
Appendicitis	21736.54	38	0
Asthma	59713.3	38	0
Cellulitis	50993.48	38	0
Chronic obstructive pulmonary disease	219789.9	38	0
Congestive cardiac failure	60260.67	38	0
Convulsions and epilepsy	90303.47	38	0
Dehydration and gastroenteritis	94550.4	38	0
Dental conditions	162774.8	38	0
Diabetes complications	5404867	38	0
Gangrene	2264.69	37	0
Hypertension	14399.11	36	0
Influenza and pneumonia	16185.76	38	0
Iron deficiency anaemia	18103.05	38	0
Nutritional deficiencies	25.80456	27	0.529466
Other vaccine-preventable conditions	3785.348	37	0
Pelvic inflammatory disease	3874.382	38	0
Perforated/bleeding ulcer	1294.571	38	0
Pyelonephritis	53074.83	38	0
Total acute conditions	1897448	38	0
Total chronic conditions	8324854	38	0
Total selected potentially preventable hospitalisations	14807344	38	0
Total vaccine-preventable conditions	20698.8	38	0

The results of these analyses are shown in Table A.17. For each category the null deviance, degrees of freedom, and the results of the test of the null hypothesis are shown.

As can be seen the only category for which the null hypothesis cannot be rejected is for the nutritional deficiencies category. For all of the other categories the p-value is 0.0 and hence the null hypothesis is rejected. This indicates that for all of these PPH categories there is enough significant variation between cells to indicate that SEIFA deciles and ASGC remoteness categories are important in determining the standard rates.

A5.3 Conclusions

HMA has provided TRC – Mathematical Modelling with a set of averages of scores of various medical conditions, collated by socio-economic and regional conditions. These data have been analysed to determine whether there is any statistical significance in these averages due to the socio-economic and regional conditions. This statistical analysis indicates that for all but one of the PPH categories there is enough variation between data cells to indicate the cell's SEIFA decile and ASGC remoteness categories are significant. Note that the conclusions and statements of statistical significance are heavily reliant on the Poisson assumption. If further analysis is to be attempted, validation of this assumption should be undertaken.

ATTACHMENT B: FORMAT FOR TELEPHONE CONSULTATIONS

Background information

- (1) Who is/may be a member of your organisation?
- (2) Are there any estimates of the number of consumers represented by the organisation? (if 'no', go to question 4)
- (3) What is the source/basis of that estimate?
- (4) We are seeking a *very rough guide* about the importance of access to medications by consumers represented by your organisation. What proportion of xxx *[the consumer group represented by the organisation]* would be considered:
 - (i) average users of prescription medications (similar to levels across the general population)?.....%; and/or
 - (ii) moderately heavy users of prescription medications?%; and/or
 - (iii) heavy users of prescription medications?%; or
 - (iv) don't know/no idea!
- (5) Has there been any previous work undertaken by *[organisation name]*, or other groups with an interest in the area, into barriers by xxx *[the consumer group represented by the organisation]* accessing prescription medicines?
 - (i) Yes (please describe the nature of that work – consultations, policy statements, research, other – and describe its conclusions; can HMA obtain a copy of this material?)
 - (ii) No (if 'no', go to question 8).
- (6) Does your organisation have anecdotal evidence that leads you to consider that there are barriers to access to medicines for you members?
- (7) Have there been any new issues emerge around barriers to access for xxxx *[the consumer group represented by the organisation]* since this work was done?

Affordability Access Issues

- (8) In general are all required medications (prescription or otherwise) affordable for the xxx *[the consumer group represented by the organisation]*?
- (9) How effective is the design of the PBS in facilitating affordable access to prescription medicines? (safety net eligibility criteria / level of the safety net/ administrative arrangements for the safety net).
- (10) Is there any evidence that affordability of prescription medicines for xxx *[the consumer group represented by the organisation]* has changed in recent years?
- (11) *[For chronic illness, mental illness, intellectual and physical disability organisations].* Are there any estimates of the average cost/expenditure by xxxx *[the consumer group represented by the organisation]* on prescription medicines? (for other groups go to question 12).

- (12) Are generic drugs available for common illnesses related to the condition(s) experienced by xxxx [*the consumer group represented by the organisation*].

Accessibility Access Issues

- (13) Is proximity to a GP or community pharmacy a problem for some or all consumers represented by the organisation?
- (14) [*For remote/rural health organisations*]. How do people in remote communities access prescribed medicines where there is no locally accessible GP or community pharmacy?
- (15) [*For remote/rural health organisations*]. How important/effective is the role of the community nurse/nurse practitioner in providing access to prescribed medications in remote communities?
- (16) How could access to a GP or community pharmacy services be improved for people in remote/rural communities?
- (17) [*For indigenous organisations*]. Why has the take-up of s100 arrangements by AMS/community pharmacies servicing remote areas been so small? How could this take-up rate be improved?

Availability Access Issues

- (18) Are consumers aware of the range of services now provided by community pharmacies, other than routine dispensing (consumer medicines information (CMI), disease management, home medication reviews (HMRs)?
- (19) To what extent are pharmacies delivering this broader range of services available?
- (20) [*For chronic illness, mental illness, intellectual and physical disability organisations*]. Does CMI adequately address the usage needs of people with chronic illness, mental illness, intellectual or physical disability conditions?
- (21) [*For people from CALD/ indigenous backgrounds*] To what extent are consumers from these backgrounds accessing the range of services other than routine dispensing?
- (22) [*For people from CALD/ indigenous backgrounds*] Are there cultural/linguistic/educational issues which prevent consumers accessing GP or community pharmacy services?

Acceptability Access Issues

- (23) [*For people from CALD/ indigenous backgrounds*] What is known about the cultural acceptability of the GP and community pharmacy services offered?

Concluding Questions

- (24) How would you rank each of the access barriers in relative importance to the consumer group that you represent? (where most important eg affordability = '1' and least important eg acceptability = '5')?
- (25) Are there other access issues not raised through this list of consultation questions that you think should be considered when formulating research proposals around consumer barriers to accessing medicines?

ATTACHMENT C: SUMMARIES OF TELEPHONE CONSULTATIONS

Rural & Remote Perspectives

Health Consumers of Rural and Remote Australia (HCRRA)

Date: Wednesday, 25 May 2005

Interviewee: Ms Margaret Brown, National Chairperson

Background Information

HCRRA provides a national voice to help improve health outcomes for those living in rural and remote regions of Australia. It *does not* however become involved in the specialised area of indigenous issues. HCRRA is a member of the National Rural Health Alliance. HCRRA has also been involved in the advising on the development and implementation of the Rural Pharmacy Incentive Program and NPS Community Quality Use of Medicines Programs.

HCRRA's policy and major focus is on helping to provide services which enhance:

- community access to transport to health services;
- the provision of quality aged care support and accommodation; and
- the communication of relevant, up-to-date health information.

Ms Brown saw rural and remote communities as being average level users of medicines, but somewhat disadvantaged (compared to urban communities) regarding access to medicines.

Stakeholder comments

"Not all towns have a pharmacist and not all towns have a resident GP. Some people are forced to drive 70km or more to get to one. This creates real issues in terms of increased access time and higher fuel costs – and if anything the problem is worsening."

Affordability Access Issues

This is seen as a major issue with increases to the PBS safety net and many rural farming areas experiencing difficult/drought conditions being cited as key factors.

Stakeholder comments

"You hear of people taking half a tablet for their diabetes instead of the full tablet they need."

Further Research Pointers:

- *Investigate whether transport/distribution costs make prescription drugs more expensive in rural and remote areas compared to city/urban centres ie is the average price beneath the maximum patient co-payment level higher in non-metropolitan areas?*

Accessibility Access Issues

Attracting and keeping both doctors and pharmacists in remote areas is an ongoing problem.

In places where either professional groups does not operate, ‘the tyranny of distance’ becomes a key barrier to accessing prescription medicines in a timely manner. It can also result in people ‘stockpiling’ medications and then facing the potential danger of using unsafe/out-of-date/ineffective medicines.

Ms Brown was unsure as to whether there was scope for s100 principles to be extended to improve access to prescription medicines for non-indigenous communities in remote areas. An alternative to AMSs as the service delivery mechanism was not clear. She did say, however, that some flexible, lateral thinking was required with respect to improving access for people who have little choice but to live in remote areas. Mention was made of how effective some Royal Flying Doctor Service ‘Medical Boxes’ were in meeting the needs of people living on remote stations. She mentioned there was scope for greater uniformity around use of medical boxes across all operational arms of the RFDS.

The further use of couriers and electronic communication of information between pharmacies were also seen as possible positive steps.

Local ‘work arounds’ were developed in order to facilitate access, including use of school bussed to pick up scripts and return with medicines, and faxing/emailing prescriptions and then sending them back by courier. Ms Brown said that Pharmacy Boards were not equally receptive to condoning these work arounds.

Further Research Pointers:

- *Document alternatives for pick-up and delivery of prescriptions in rural and remote areas and*
 - *establish the level of Board support for these alternative arrangements; and*
 - *develop submissions to Boards seeking greater uniformity of approach across state and territories.*
- *Document RFDS operational arm policies around content and delivery of medical boxes and seek greater uniformity.*

Availability Access Issues

There appears to be some issue with pharmacies not always stocking what doctors are prescribing. Patients then have to either wait for their medications to be ordered in or for the pharmacist to contact the prescriber to alter the brand to dispense. A contributing factor here is that different visiting locum GPs often have their own personal preferences for prescribing medicines of certain brands or types which may be different to the regular GP.

With regard to services and information offered in pharmacies, it was felt that pharmacists are generally very good with assisting people with the best courses of action for their ailments and advising them of alternative medications – despite them having limited time. However, Ms Brown had little specific knowledge of CMI or HMR services.

It was felt more consumer information is needed on the use (and appropriateness) of cheaper generic drugs.

Further Research Pointers:

- *Scope for specification of a minimum formulary within community pharmacies (content, size).*

Acceptability Access Issues

A key issue raised here centred on lack of patient privacy in pharmacies and the problem of ‘small town gossip’. A young woman seeking to discuss a sensitive personal issue eg pregnancy testing, or a person suffering from HIV may have to travel some distance from their local pharmacy to avoid becoming the ‘talk of the town’.

Further Research Pointer:

- *Survey pharmacies to identify the proportion that have appropriate patient counselling areas.*

Ranking of Access Measures in order of importance

1. Affordability /Accessibility (equal weighting)

2.

3. Availability

4. Acceptability

Health Consumers of Rural and Remote Australia (HCRRA)

Date: Wednesday 25 May 2005

Interviewee: Ms Vianne Brain, Tasmanian Committee Member

Background Information

An HCRRA member for the past 8 years, Ms Brain resides in the small (150 people) farming and logging town of Ouse in central Tasmania, a one and a half hour drive from Hobart. The town has no community pharmacy. Instead, a GP and two nurses currently operate out of a ten bed hospital where the doctor also dispenses drugs from a 'locked cupboard'.

It was mentioned that there have been real difficulties in keeping a doctor in the town - despite them receiving incentives of a house and car.

Stakeholder comments

"We've probably had 20 different doctors in the last 10 years.... We've had a couple of Bangladeshi doctors and their families who were lovely, but lonely – mainly due to cultural differences making it hard for them to mix socially. The town certainly made a big effort to make them feel welcome. We've also had a few older doctors here who weren't always 'up with it' in respect of their knowledge of newer medications."

The continual changing of doctors has resulted in a lack of continuity in prescribing practices.

Affordability Access Issues

Describing Ouse as "not a wealthy community", Ms Brain cites deletions off the PBS list, the raising of the PBS Safety Net and lack of consumer knowledge regarding cheaper generic substitutes to prescribed medications as key barriers to affordable access.

It should be noted that higher than average petrol prices and the rough roads that cause increased wear and tear on vehicles in this area further impinge on peoples' disposable income. The nearest discount pharmacy is also an hour and a half drive to Hobart.

Further Research Pointers:

- *None identified*

Accessibility Access Issues

For towns without a pharmacy, 'webster packs' (providing up to four months supply) were helpful. It was also thought that improving access to pharmacies requires speeding up the transport of scripts. In Ouse, transport of urgent prescriptions for people without their own transport is currently done by mail or via an 8 seater community bus. The bus (when available) is sometimes used to take people (particularly the elderly) on 'shopping trips' to access larger towns, including pharmacy services.

Further Research Pointers:

- *None identified*

Availability Access Issues

Reliance on the mailman to deliver scripts does cause delays of a few days and the absence of a fully stocked pharmacy also results in medications needing to be ordered in. Ms Brain believes that everything that can be done to provide services that improve peoples' understanding of the 'quality use of medicines' and allay their fears/reservations about using particular medications should be actively pursued. She felt HMRs and CMIs were "marvellous, but limited in their current application" and that it was also important for people to have a list of current medications they are on - "Often they just can't remember".

She welcomed all forms of up-to-date, educative literature being available to consumers in pharmacies and thought the double-sided A4 information sheets she had seen were excellent.

Further Research Pointers:

- *None identified*

Acceptability Access Issues

The key point made here was that it would be preferable to have a specialist pharmacist who is up with all the latest medications in town rather than GP who is performing the dual role of prescriber and dispenser.

Further Research Pointers:

- *None identified*

Ranking of Access Measures in order of importance

1. Accessibility

2. Affordability

3. Availability

4. Acceptability

National Rural Health Alliance (NRHA)

Date: Friday, 27 May 2005

Interviewee: Mr Gordon Gregory, CEO

Background Information

The National Rural Health Alliance (NRHA) is the peak body working to improve the health of Australians in rural and remote areas. It is comprised of 24 member bodies (see list attached), representing both health consumers and service providers in non-metropolitan areas. These are all national bodies in their own right or the rural special interest groups of national bodies.

The NRHA also has some involvement with NACCHO with respect to Section 100 dispensing of prescription medications to indigenous communities via Aboriginal Medical Service outlets.

Around 6 million Australians (30% of the population) are defined as living in regional, rural and remote areas (which exclude capital cities and major regional coastal centres); 2.8 million Australians live in remote areas defined as having a population of less than 1000 people.

Mr Gregory sees consumer access to doctors, allied healthcare professionals (eg remote area nurses) and pharmacists as centrally important to the timely provision of medicines and the reduction of hospital admission rates. He also emphasised the central role of doctors in facilitating access to medicines.

Stakeholder comments

“Doctors are the key. They write the scripts that the pharmacist (if one exists) then fills.”

Affordability Access Issues

As a general statement, Mr Gregory emphasised that:

- rural and remote people were financially poorer than city dwellers;
- selected from a lesser range of stock in pharmacies; and
- had less choice of both premium and generic brand medications.

He also observed that country people tend to be more ‘risk averse’ than city people and are therefore less willing to change from buying their usual brand to purchasing a generic (despite it probably saving them money).

Further Research Pointer:

- *develop a promotional campaign targeted at regional consumers, encouraging the use of generic drugs.*

Accessibility Access Issues

A key point was made that ease or difficulty of access to pharmacy dispensing is invariably determined by whether or not a doctor/prescriber exists. The financial viability of pharmacies in rural and remote areas with doctors can be a concern; where doctors do not exist to write prescriptions, pharmacies can struggle to remain viable.

Stakeholder comments

“If there’s no doctor, there’s not going to be a pharmacist in town.”

There was also discussion surrounding the potential of increasing access to prescribers via Remote Area Nurse Practitioners – people specially accredited to diagnose and prescribe medications (within set limits) in certain situations where doctors were not available to do so.

Mr Gregory saw merit in the principle of this approach, but noted that there are unresolved issues regarding legal indemnities and the acceptability of such a move by doctors - most of whom would see it as ‘treading on their territory’.

Further Research Pointer:

- *Adequacy of financial incentives for pharmacies to remain operating in rural and remote areas.*

Availability Access Issues

Where pharmacies do exist, the question was raised here as to whether rural and remote pharmacists have the physical time, competence and appropriate incentive to implement and utilise the likes of HMR and CMI services.

Further Research Pointers:

- *Focus group analysis of what limits consumers accessing CMI and initiating HMRs in rural and remote areas.*
- *Focus group analysis of what limits community pharmacists in the promotion of CMIs and triggering HMRs in rural and remote areas [this area may already have been examined in the external evaluation of the HMR program].*
- *Focus group analysis of what limits doctors in initiating HMRs in rural and remote areas [this area may already have been examined in the external evaluation of the HMR program].*

Acceptability Access Issues

It was felt that pharmacies need to be more sensitive to the significant cultural differences between Anglo, CALD and indigenous Australians in their dealings with consumers.

The issue of ‘small town gossip’ was raised and the need for greater privacy regarding patient/pharmacist conversations. Even something as simple as asking for a pack of condoms can result in social stigma if seen/overheard by the ‘wrong person’.

Mention was also made of the high proportion of overseas trained doctors there are in rural and remote areas compared to the cities/larger regional centres. Questions were raised of whether this presented communication/language/professional interaction barriers with pharmacists they deal with.

Further Research Pointer:

- *Survey pharmacies to identify the proportion that have appropriate patient counselling areas.*

Ranking of Access Measures in order of importance

1. Accessibility

2. Affordability

3. Availability

4. Acceptability

Council of Remote Area Nurses of Australia (CRANA)

Date: Thursday 9 June 2005

Interviewee: Mr Rod Wyber-Hughes – Executive Officer

Background

Remote Area Nurses (RANs) are specialist nurse practitioners who provide and coordinate a diverse range of health care services for remote populations within Australia and its Territories. They practice in isolation from tertiary services and can sometimes be up to 1000km away from the nearest hospital.

Stakeholder comments

“Without RANs, there’d be no health service out there [in remote areas] at all”

RANs undertake appropriate educational preparation for their practice.

RANs provide their services in everything from small clinics (which may be just a house with a basic pharmacy setup) to quite sophisticated multi-purpose centres. They are frequently involved with Aboriginal Medical Services, where they have a key part to play in providing information on medication usage, and also perform “roaming work” that involves travelling to out-stations.

Their role is a demanding one. They are on-call 24hours a day and can do upto ‘3 month stints’ before taking a break. Their day can involve everything from providing people with natal care to heart care; and 90% of the time they are in a position where they have no physical access to a resident/visiting GP and only have phone contact with doctors/other qualified healthcare professionals to receive advice/assistance.

In dispensing and prescribing medications in the Northern Territory, RANs commonly follow the guidelines set out in the ‘Central Australian Rural Practitioners Association (CARPA)’ manual which covers a broad spectrum of healthcare disciplines and courses of action for RANs to take in specified situations eg regarding advice on usage and when consultation with a doctor is required before dispensing of a medication.

With regard to the imprest generally available to RANs, Mr Wyber-Hughes believed that this tends to incorporate generic and ‘core drugs’ with real limitations on branded choices – particularly where there is a lack of a central (and well-stocked) pharmacy in the vicinity. He pointed out that this situation in remote places often compromised the level of efficacious treatment compared to urban areas. It was felt that state and territory agreement on a standardised protocol on drug availability would help to address this issue.

Other barriers to accessing prescription medicines were identified as low literacy levels, language difficulties and cultural differences, particularly with respect to indigenous communities.

Further Research Pointers:

- *Investigate scope for greater standardisation in prescribing/dispensing guidelines for RANs eg roll-out of the CARPA guidelines (which currently only have legal status in the Northern Territory) to other Australian states and territories.*
- *Explore scope for establishing a universal drug imprest list to create greater uniformity of what medications RAN personnel keep on hand in their pharmacy cupboard.*
- *Assess scope for roll-out of the remote area pharmacist model operating in the Ngaanyatjarra Health Service in Western Australia. Under this model a pharmacist has been appointed to provide a range of services including clinic reviews (of RAN dispensing activity), HMRs, imprest stock checks, advice to individual patients eg at 'sorry camps'. This Pilot Program is still in its early stages and that any roll-out would be dependent on its ultimate success in meeting objectives. It is funded under the Third Pharmacy Agreement.*

Chronic Illness Perspectives

Arthritis Victoria (AV)

Date: Tuesday, 31 May 2005

Interviewee: Ms Liz Bongetti, Principal Health Professional

Background Information

An independently run, not-for-profit health organisation, the key focus of Arthritis Victoria is to improve the quality of life of people with arthritis, osteoporosis and other musculoskeletal conditions through the provision of a broad range of programs and services. This body also aims to prevent disability, promote self management and positive health and fitness, increase independence and support the efforts of carers.

Arthritis is Australia's major cause of disability and pain. Today, more than 3.4 million Australians (16.7% of the population) have some form of arthritis at an estimated total cost to the community of \$11.2 billion each year⁵⁷ More than 100 forms of arthritis have been identified, including osteoarthritis, rheumatoid arthritis, gout and lupus.

Access to medicines is generally felt to be a major issue for arthritis sufferers as they tend to be relatively high users of prescription medications, particularly high dose, non steroidal anti-inflammatories.

Ms Bongetti pointed out that in recent times there had been some medications withdrawn from the world and Australian market due to adverse side effects eg *Vioxx (Rofecoxib)*. Until this occurred, Vioxx was widely regarded as a safe and effective anti-inflammatory agent. It is estimated that at least 250,000 Australians were taking it for their arthritic condition. Ms Bongetti believes the outcome of such a widely publicised withdrawal tends to undermine consumer confidence in the *whole group* of anti-inflammatory medications.

Affordability Access Issues

It was mentioned that many people who suffer from arthritis also have other chronic conditions needing treatment. Many are pensioners and utilise the PBS safety net provisions that assist with the financial burden of requiring multiple medications.

Generic non-steroidal, anti-inflammatories are commonly available.

A key affordability issue centred on people with osteoporosis – some medications are only available under the PBS if a bone fracture *actually occurs*. This has the effect of disadvantaging people who need financial support from the PBS for medications to assist in the *prevention* of fractures.

AV did not know how much self-funding of medications took place by people suffering from arthritis or other musculoskeletal conditions.

⁵⁷ www.arthritisaustralia.com.au

Further Research Pointer:

- *Frequency of off-label use / number of PBS listed drugs that are being prescribed for osteoporosis that are non-PBS compliant.*

Accessibility Access Issues

The effect arthritic conditions have on diminishing peoples' mobility raises the barrier of being less able to use public transport and/or drive a car to visit a pharmacy, GP or specialist eg rheumatologist.

In rural and remote areas, geographic access to specialist prescribers in particular is even more difficult and can clearly affect timely diagnosis and treatment. There are some medications for acute/special conditions that only a specialist can prescribe. In the area of arthritis this includes *Etanercept*, which must be prescribed by a rheumatologist or an immunologist with expertise in the management of rheumatoid arthritis.⁵⁸

The reduced availability of specialists in non-metropolitan areas can also increase the time and cost of travelling to meet the prescribing doctor.

Prescribing doctor attitudes can act as a barrier to access in relation to medications for osteoporosis. AVs view is that some doctors have an inappropriate perception in relation to sufferers; "some consider it too late to prescribe or see people as too old to justify prescribing medicines for the management of osteoporosis".

Further Research Pointers:

- *Number and appropriateness/effectiveness of PBS conditions placed on circumstances for prescribing of medications;*
- *Appropriateness of drugs being classified under the s100, Highly Specialised Drugs program.*

Availability Access Issues

Whilst it was generally felt that consumers are becoming more aware of information and advisory support services in pharmacies (and that these were improving in quality and availability), little was known on the extent of usage of CMIs, HMRs and the NPS 'Medicine Line'.

Further Research Pointers:

- *Focus group analysis of what limits consumers accessing CMI and initiating HMRs.*

⁵⁸ The Blood and Pharmaceutical Programs Section of the Department of Human Services, Victoria has advised HMA that there is a growing trend to specify restrictions about the type of specialist that must prescribe a drug listed on the general PBS. Other examples: *Aracept*, which must be prescribed by a specialist consultant physician, and after administration of a test of cognitive functioning.

- *Focus group analysis of what limits community pharmacists in the promotion of CMI's and triggering HMRs [this area may already have been examined in the external evaluation of the HMR program].*
- *Focus group analysis of what limits doctors in initiating HMRs [this area may already have been examined in the external evaluation of the HMR program].*

Findings from this research could be used to develop a promotional / advertising programs in each stakeholder area.

Acceptability Access Issues

A point raised here was that consumer preference is increasing for natural products eg glucosamine as opposed to manufactured compounds that are perceived to have more side effects. It was also mentioned that some arthritis sufferers whose hand functions are impaired have difficulty with opening the packaging of their medications (these issues relate to QUM once prescribing has occurred).

Juvenile arthritis is a relatively rare form of the disease (around 1 sufferer per 1,000 children). Pharmacists often express surprise / alarm when they are asked to dispense *Methatrexate* for children, which is prescribed to help manage the condition. This reaction can cause anxiety to the parents purchasing the medication.

Further Research Pointer:

- *Development of a program for improved community pharmacist customer management techniques.*

Ranking of Access Measures in order of importance

- 1. Accessibility**
- 2. Affordability**
- 3. Availability**
- 4. Acceptability**

Arthritis and Osteoporosis: Additional Details

Few Australians do not know someone with arthritis and/or osteoporosis and, although very many of those affected lead reasonably normal lives, many others are very seriously affected. In order that their needs for support and therapy are recognised, the following data has been collated from the National Health Survey 1995, published as ABS Cat No. 4392.0 and ABS Cat No. 4364.0 and a special study of Arthritis and Osteoporosis from the same data base.

Affecting 14.6% of the Australian population, arthritis was by far the most common chronic condition. This demonstrates a most distressing situation and one worthy of concern by all who can contribute to the needs of those affected.

Musculoskeletal disease – the Australian experience

4,127,144 Australians experience, on a long-term basis, a form of musculoskeletal disease. Of these, the following are the numbers of Australians affected:

- Sciatica / disk problems / back problems: 872,007
- Curvature of the spine: 52,357
- Osteoporosis: 247,340
- Rheumatoid arthritis: 474,820
- Osteoarthritis: 1,159,064
- Arthritis n.e.c: 1,048,937
- Total arthritis: 2,632,273
- Rheumatism: 301,502
- Other musculoskeletal: 1,117,542

If the data relating to arthritis on a long-term basis is directly compared with data presented in the previous national health survey, it measures an increase of 829,900 or 8% per annum.

The age of half of the people with arthritis is 60 or less. 60.5% of those reporting any form of arthritis are female. 6,700 of those reporting arthritis on a long-term basis are aged 14 or less and 63,300 are aged 24 or less.

If the incidence of arthritis remains constant within existing age groups and the population increases at the rates projected by ABS, the number of people affected and the proportion of the population will be as follows:

	Number	%
1995	2,633,340	14.6
2001	2,968,084	15.4
2021	4,191,100	18.6
2051	5,242,900	21.1

Health Care Delivery

Diseases of the musculoskeletal system and connective tissue together account for:

- 11.7% of hospitalisation events;
- 11.3% of casualty / outpatient events;
- 6.0% of day clinic visits;
- 8.9% of consultations with a doctor; and
- 27.5% of consultations with a health professional.

12.7% of persons who took medications were people with a musculoskeletal or connective tissue disease.

The data are from the special study of arthritis and osteoporosis presented in the tables below, and show certain behaviours which took place in the two weeks prior to the survey being conducted.

These data show that people with any form of arthritis or with osteoporosis:

- made 24.7% of the consultations with a GP;
- made 28.9% of visits to a specialist; and
- represented 34.5% of those people found to need to consult with a doctor on four occasions or more during the two weeks measured.

Pharmaceutical

People with arthritis and/or osteoporosis are recognised by the Arthritis Foundation as being major users of alternative or unproven medications. This view is borne out by the medications usage data which show “unspecified medications” as the major source of pharmaceutical usage by them.

The general health of people with arthritis and osteoporosis also shows in the data relating to medication usage in which people with arthritis and osteoporosis were found to be dominant users of arthritis medications, fluid tablets and diuretics, sleeping medications, heart or blood pressure medications, medications to lower cholesterol and triglycerides, tranquillisers, and stomach medications and laxatives.

Behaviours

The statistics also show the other actions taken by people with arthritis and osteoporosis. The most common health professionals consulted were:

- Physiotherapist / Hydrotherapist: 84,000;
- Chemist: 74,100;
- Chiropractor: 58,000; and
- Chiropodist/Podiatrist: 56,800.

These four specialisations accounted for more than half of the health professional consultations and people with arthritis and/or osteoporosis account for the following percentages of health professional practice:

- Chiropodist/Podiatrist: 51.1%
- Acupuncturist: 36.5%
- Hypnotherapist: 35.4%
- Physiotherapist / Hydrotherapist: 30.4%

Other data indicates that people also take the advice of family and friends with 113,400 reporting such an event in the two weeks studied.

Summary

Musculoskeletal diseases have been calculated by The Australian Institute of Health and Welfare to cost \$3 billion per annum, the third most costly group of conditions and 9.5% of total health care costs.

Diabetes Australia (DA)

Date: Monday 30 May 2005

Interviewees: Mr Trevor Corbell – Manager, National Advocacy; Ms Maria Murphy – Director, National Diabetes Services Scheme

Background Information

DA is the peak national body for diabetes in Australia. The federation comprises twelve major diabetes organisations. DA advocates on behalf of all Australians with diabetes – estimated to be 1.2 million people – as well as their friends, family and carers.

The National Diabetes Services Scheme (NDSS) is a Commonwealth Government initiative administered by Diabetes Australia since 1987. This program provides blood and urine testing strips, syringes and needles for special injection systems at subsidised prices to people diagnosed with diabetes who register for its benefits. Its aim is to enhance the capacity of people with diabetes to understand and manage their life; and to ensure they have timely, reliable and affordable access to the supplies and services they require to effectively self-manage their condition. Currently, the NDSS has 670,000 registrants.

Diabetes is a chronic illness which is often accompanied (and complicated) by heart disease. DA estimates that sufferers are 6 to 7 times more likely to be recipients of prescription medications than the rest of the Australian population.

A distinction needs to be made between the two main types of diabetes as the medications required to treat them are quite different:

- (1) **Type 1 Diabetes.** Sufferers are insulin dependent and tend to be younger; they produce no insulin in their bodies naturally and require it to be injected. Depending on the degree of complications, the annual cost to the individual (including medications and associated social costs) is up to \$15,000pa.
- (2) **Type 2 Diabetes.** This group is by far the largest (530,000 of the 670,000 NPSS registrants) and tend to be older non-insulin users. Their main requirement is for oral hypoglycaemic agents to manage the control of their blood glucose levels. Depending on the degree of complications, the annual cost to the individual (including medications and associated indirect costs) is \$6000-\$10,000pa.⁵⁹ DA advised that people in this category without complications (around 50%) would be moderately heavy users of prescribed medications. The remaining 50% of Type 2 diabetes sufferers would be heavy users of medications.

Gestational diabetes is also a temporary condition which affects around 15,000 pregnant women at any given time.

⁵⁹ Colaguri, S., *et al.*, Diab CoSt Australia: Assessing the Burden of Type 2 Diabetes in Australia, Canberra, 2003

Affordability Access Issues

Whilst cheaper generics are available for conditions like cardio-vascular disease (CVD), which is a co-morbidity often experienced by diabetes sufferers, insulins are non-generic. This affects the cost of medicines for people with Type1 diabetes until the safety net provisions come into operation for an individual. The recent increase in the safety net level, reflecting higher co-payments, will mean a further delay for some people before the safety-net provisions come into effect.

DA questioned the effectiveness of the administrative arrangements for the safety net. Concerns over patient stockpiling did not warrant the delays in accessing higher levels of subsidy experienced by people with a chronic illness, like diabetes. It was felt that chronic sufferers are disadvantaged under the current PBS co-payment and safety net arrangements; costs need to be amortised over a 12 month period to assist with patient cash flow issues.

Whilst insulin pump consumables are listed on PBS, the actual pump itself (costing \$6,000 - \$10,000 to buy) is not. This financially disadvantages people with unstable diabetes who need the pump to even out the flow of insulin and control their blood glucose levels. For people who do not have / cannot afford private health insurance, it is a matter of having to run 'lamington drives' to raise the money they need for the pump.

It was mentioned that there can be 3 to 4 year lead times in getting new products listed on PBS. Where these are comparatively high cost medications (eg Glargine Insulin) gaining PBAC approval can result in long debates over the clinical benefits and multiple, time consuming submissions.

It was also noted that there was 'unfairness' associated with the different listings on the PBS and the Repatriation PBS (RPBS). Older diabetic men who are not veterans are ineligible for subsidised *Viagra* for erectile dysfunction whilst veterans are, because the drug is listed on the RPBS. This forces some people to make a financial trade-off between using *Viagra* rather than, say, lipid reduction medication.

DA had anecdotal evidence of people only taking half their daily dosage of a medicine to make it last longer and delay re-purchase. This behaviour was provoked by the overall cost burden that was experienced by some people in managing the disease.

Further Research Pointers:

- *Efficacy of variations in PBS and RPBS listings*
- *Circumstances / criteria for fast tracking the PBAC approval process for different categories of new drugs*

Accessibility Access Issues

There was a general view expressed by DA that 5000 PBS registered pharmacies "isn't too bad" with respect to allowing good levels of consumer access and identifying a subset of NDSS community pharmacy outlets, including in rural and remote locations (other NDSS outlets include Aboriginal Medical Services (AMSs)).

Further Research Pointers:

- *None identified.*

Availability Access Issues

Because insulin is a refrigerated item, supplies are not stockpiled by pharmacies and need to be ordered in according to consumer demand.

With respect to services provided in/to pharmacies, NPSS offers one-to-one counselling and education/training of both pharmacists and assistant counter staff. HMRs were seen to be operating at lower than optimum levels

Further Research Pointer:

- *See comments relating to CMI and HMR in response to the Arthritis Victoria interview.*

Acceptability Access Issues

Creating settings for patient/pharmacist privacy of advice on insulin/injecting was cited as a needed improvement. There are real sensitivities among new users, with some not wanting to disclose their condition because, for example, they may be seen as a workers' compensation risk.

Some pharmacies accept used needles but some do not. There should be more uniformity in approach around this issue. There are again sensitivities among insulin injecting people with diabetes of not wanting to be seen visiting needle exchange centres which are most often associated with illicit drug use and/or addicts.

Further Research Pointers:

- *Survey pharmacies to identify the proportion that have appropriate patient counselling areas.*
- *Survey pharmacies to identify the proportion that run needle exchange services.*

Ranking of Access Measures in order of importance

1. Accessibility

2. Availability

3. Affordability

4. Acceptability

Epilepsy Australia

Date: Monday 30 May 2005

Interviewee: Mr Russell Pollard - CEO

Background Information

The national peak body, Epilepsy Australia is a nationally registered charity, whose member associations work together to achieve the best possible outcomes for all Australians living with epilepsy and to support the Australian community in making enlightened and fully informed responses to epilepsy.

Each Australian state or territory has its own community based epilepsy association set up by people who have experienced the reality of living with epilepsy in that state or territory. Members come together formally at least four times a year, and many other times through email, teleconference, and special purpose meetings, to gain the synergy that can come from sharing common tasks, resources, publications, training opportunities, and a number of programs for people living with epilepsy eg the Epilepsy Foundation Victoria Accommodation Project which finds accommodation for people whose physicians have sent them to Melbourne for tests and other procedures (usually prior to brain surgery) or the implantation of a vagal nerve stimulator.

It is estimated there are 180,000-200,000 Australians who suffer from epilepsy. This equates to around 1 in 100 having the illness at any given time. Some 300 people die from the illness (or the complications) it causes each year.

With proper medication, 60% of people with epilepsy are able to avoid seizures and get their condition under control within 2 years. An estimated 30% are deemed intractable cases and do not succeed in gaining freedom from seizures.

Mr Pollard made the point that for 99.9% of the time, people suffering from epilepsy are essentially no different to other people and want to be accepted as such. When an episodic 'fit' does occur, however, there is a tendency (misinformed as it is) for many in the community to feel uncomfortable with this neurological disorder and associate it with some form of mental illness. Hence, there is a very real social stigma attached to epilepsy which needs to be broken down.

Affordability Access Issues

Whilst many people with epilepsy are on multiple medications and often need to take anti-convulsants long-term to control/avoid seizures, it appears that most older/proven and more recent/ expensive medications are PBS listed to help ease the financial burden. The PBS threshold will also usually be reached by many patients who are on multiple medications.

Mr Pollard indicated that there have been instances of pharmacy staff offering people suffering from epilepsy cheaper generic versions of branded products they had been

prescribed and were used to taking. His firm view is that epilepsy is an illness where the use of generic alternatives can be less effective / efficacious and changes to the regular brand of medication prescribed can lead to ‘seizure breakthroughs’.

A further issue regarding affordability is that many GPs do not feel adequately equipped to diagnose and treat epileptic patients and commonly refer them to specialist neurologists whose services cost more.

Finally, it was pointed out that epilepsy is a ‘high impact’ illness and sufferers cannot afford to miss their medication because of the potential impacts on management of the disease.

Further Research Pointers:

- *None identified.*

Accessibility Access Issues

This is a key issue in respect of having access to both the ‘right drug(s)’ to control each individual’s condition and also access to a prescribing neurologist. As with most chronic illnesses requiring specialist treatment, rural and remote residents are often forced to travel some distance to get the professional help and prescription medication they require.

An issue here is that there are sometimes legal restrictions on people with epilepsy being able to drive a car. State traffic authorities require people with epilepsy to be seizure free for set periods that vary according to the types of seizures that individuals experience eg nocturnal, wake-up. A case was cited of a man in Queensland being jailed for 7 years for killing others in a car accident that occurred as a result of him having a seizure at the wheel.

Further Research Pointers:

- *None identified.*

Availability Access Issues

Mention was made that some medications under PBS are not specifically listed for epilepsy in the PBS but are used by some people with epilepsy to control/treat their condition.

The extent to which HMRs and CMIIs are used in this area is unclear, but was felt to be a good idea in principle by Mr Pollard.

There was some issue of pharmacies not keeping stocks of certain antiepileptics, notably those at the more expensive end of the scale.

Further Research Pointers

- *Scope for specification of a minimum formulary within community pharmacies (content, size)*

Acceptability Access Issues

Barriers raised here were that some medications for epilepsy produced unpleasant side effects. Because of the social stigma attached to epilepsy, it was also felt that more patient privacy was required in pharmacies/dispensing outlets to discuss matters. People

suffering from epilepsy tend to be secretive of their condition and sensitive to the implications that could result, for example, if their employer became aware of their illness.

Further Research Pointers:

- *None identified.*

Ranking of Access Measures in order of importance

- 1. Accessibility** (to both prescribing specialists and medications)
- 2. Availability**
- 3. Acceptability**
- 4. Affordability**

National Asthma Council of Australia (NAC)

Date: Friday 10 June 2005

Interviewee: Ms Kathy Hope

Background Information

An 'umbrella' organisation for all asthma bodies in Australia, the goal of the NAC is to bring together all forms of endeavour in the field of asthma in order to:

- improve the quality of life and health outcomes of people with asthma and their carers;
- reduce the social and economic impact of asthma on the community;
- reduce the prevalence of asthma in the Australian community.

The NAC is actively involved in:

- providing the latest information on asthma to health professionals directed at improving their quality of care;
- conducting and evaluating the delivery of national public awareness and education campaigns;
- being the national communicating authority on asthma;
- gathering, refining and disseminating information on asthma;
- taking on the role of a catalyst for change to facilitate improvement in the standards of asthma care and management.

Today, over 2.2 million Australians suffer from asthma – this equates to 10-12% of all adults and the percentage is higher still for children. More boys than girls have asthma. However, after teenage years, asthma is more common in women than in men. It is one of the most common reasons people visit a GP and it is prevalent across all parts of the country and all demographic and socio-economic groups.

A key indication that medications and management practices have improved for this chronic disease is that ten years ago some 900 people died from it each year and that this has fallen to a figure of 397 per annum⁶⁰. In most patient cases, asthma can now be well controlled.

Around 50% of asthma sufferers are deemed moderate to severe cases who require daily doses of preventer/reliever inhaler medications. Oral steroids are only prescribed short-term to control very severe flare-ups.

⁶⁰ Australian Bureau of Statistics, 2002. Causes of Death: Australia, Cat. No. 3303.0

Affordability Access Issues

Ms Hope believed the PBS system in Australia for promoting access to medicines compared extremely well to others in the world and provided good access to subsidised medication – although she did mention that the average pharmacy purchasing cost of \$30-60 per month for moderate users of asthma medications would mean most people would not reach the Safety Net threshold needed to reduce their per prescription outlay.

It was also mentioned that there was a general lack of cheaper generic brands.

The issue of medication only being one part of the cost of having asthma was also raised – with increased absenteeism from work cited as just one of many other elements.

Further Research Pointers:

- *none identified*

Accessibility Access Issues

This was only felt to be factor affecting rural/remote/indigenous communities where there is limited access to pharmacies and/or prescribers.

Further Research Pointers:

- *none identified*

Availability Access Issues

With regard to CMI and HMR services, Ms Hope saw usage as varying significantly between pharmacies and believed ‘lack of time’ for pharmacist involvement was a contributing factor to low implementation levels.

HMRs were considered to be “extremely useful” for older people, particularly in situations where they had multiple conditions beyond just asthma. General consumer awareness of this service, however, was thought to need increasing. The “high-brow” level of language often used in CMI information was felt to make it inaccessible to the average consumer, with many putting it in the ‘too hard basket’ and simply not reading/ignoring the material.

Stakeholder comments

“The level of personal relationship that people develop with their pharmacist or GP has a direct bearing on how much professional advice they receive and how aware they become of what information/services are available regarding their condition and/or medication choices. The more open the communication channels are the better the outcome.”

Further Research Pointers:

- *none identified*

Acceptability Access Issues

A point raised here was that asthma inhaler devices can be difficult for some people to use, particularly young children and those with arthritic conditions. It was felt that advice and explanation from pharmacists on demonstrating their optimum operation varied from being very good to 'not so good'.

The issue of explaining the side effects of asthma medications, especially the steroidal kind, required improvement.

Asthma sufferers belonging to both indigenous and CALD communities were often less able to communicate with/understand pharmacists due to cultural and language barriers.

Ms Hope was asked whether alternative medicines were used by people to help treat/control their asthma

Stakeholder comments

"Yes, like most people with a chronic illness, those with asthma are always looking for ways to improve their lot in life...it should be said though that there are some complementary medicines which can be very dangerous, particularly when taken in combination with other prescribed medications. It is essential for people to speak with their doctor first and always advise a pharmacist of their asthma condition before buying any over-the counter products".

Further Research Pointers:

- *Investigate the extent to which consumers are using non-prescription medications to 'self treat/manage' chronic illnesses and medical conditions generally and to also identify the impact this is having on their demand for prescribed medications.⁶¹*

Note: In terms of ranking the above access measures in order of importance, Ms Hope said that asthma was an illness so prevalent across so many different groups in society that an overall assessment of priorities was not possible. What would be right order for one group would be a different for another.

⁶¹ Reference – 'Asthma and Complementary Therapies' Information Paper No.5, www.nationalasthma.org.au

Mental Illness Perspectives

SANE Australia & Schizophrenia Australia Foundation

Date: Friday, 27 May 2005

Interviewee: Ms Barbara Hocking, CEO

Background Information

Both SANE Australia and the Schizophrenia Australia Foundation operate as national charity organisations. They are not Government funded and depend on donations and project funding. The focus of their work is consumer oriented and aimed at providing support for sufferers of mental illness generally and schizophrenia specifically. This is largely achieved through the provision of educational materials/literature that help people make sense of their illness and also systems based advocacy/campaigning at a community and government level which seeks to reduce the stigma attached to mental illness and improve the services available – including the areas of medical, psychological and rehabilitation support.

Schizophrenia is essentially a young person's disease with 75% of sufferers developing the illness between the ages of 16-25. Often, however, it is not diagnosed as requiring treatment until later stages in life. The illness is episodic in nature and can be effectively treated with the proper medications. Indeed, one in four people recover from it. Whilst 100,000 Australians have experienced the illness, the estimate is that 40-50,000 men and women currently suffer from it (possibly slightly skewed towards men).

Ms Hocking sees these people as lonely, isolated by their illness and, for the most part, craving people to take a friendly interest in them. They not only suffer from a mental illness but from people in all parts of the community being generally uncomfortable interacting/talking/spending time with them – including pharmacy staff.

Involvement with the listing of new medications under the Pharmaceutical Benefits Scheme (PBS) is a key area of importance to SANE. Mental illness patients are commonly heavy users of multiple medications - often needing anti-depressants, sedatives, drugs to control psychotic behaviour and additional medicines to negate 'other medication' side effects. Management of polypharmacy within this group is a big issue.

Affordability Access Issues

Given the common heavy usage of medications, general lack of less expensive generic brands and that some 80% of people with a psychotic illness are unemployed, affordability of prescription medicine is a major issue. As is whether or not particular medicines are PBS listed.

It should be noted that most patients on multiple medications are financially assisted by a Disability Support Pension (DSP) and therefore have access to the safety net provisions of the PBS.

Off label use is a cost issue for some people with a mental illness eg drugs that may be authorised for use in the management of schizophrenia may also be helpful in the management of bi-polar disease. This may not be an authorised PBS use and therefore result in the need for a private prescription where the full cost of the drug is borne by the user.

There is no information available from SANE on ‘how much it costs to have a mental illness.’

Further Research Pointers

- *Frequency of off-label use / number of PBS listed drugs that are being prescribed for non-PBS compliant reasons, generating a private prescription, by illness/condition.*
- *Investigate the total cost of having a mental illness ie. not just for medications but all the associated add-ons (travel time and costs)*

Accessibility Access Issues

This was not seen as a major barrier (except perhaps in remote areas). It is true though that some stages of some mental illnesses would make driving a car to get to a pharmacy or other dispensing outlet unsafe/difficult. Where medication is doing its job well, this does not present a problem.

Further Research Pointers

- *None identified.*

Availability Access Issues

Access to the ‘best available’ medications and new indications is a key issue in the effective treatment and control of each individual’s mental illness.

Whilst pharmaceutical companies have clear incentives to gain and/or extend new indications approval for PBS listing of drugs/medications, the evidence collecting process they must follow is usually lengthy and can often take years. This can operate as a real barrier to people accessing medicines that would benefit their condition in a timely manner. An instance was also cited of a drug being available in the UK, but unavailable in Australia on PBS in the same dosage required by a particular patient.

SANE has been involved with the University of Sydney Pharmacy Department (Orange Campus) in looking at the role of pharmacists in the education and support of people suffering from depression. This role could be extended:

- beyond the Orange district to other regions / jurisdictions (SANE has had preliminary discussions with the Victorian Guild for such a rollout); and
- to other mental illnesses eg schizophrenia.

Ms Hocking commented that it appeared to be harder to get PBAC approval/PBS listing for drugs relating to mental illness compared to, for example, medications that assist with the management of HIV AIDS.

There are also examples of drugs coming off patent shortly where there is minimal commercial incentive for manufacturers to market a generic drug because of the current PBS restrictions eg *Lamictal* (approved for epilepsy but also used to manage bi-polar disease). Current users face the prospect of there being no supply.

Home Medication Reviews (HMRs) appear to be a rarity in the field of mental illness. There may, however, be an opportunity for pro-active applications of this service model to be implemented in ways that more successfully address the needs of schizophrenic people. Contact could be made:

- at the time of discharge from an inpatient facility (ie triggered within the hospital); or
- facilitated through community mental health teams (also known as emergency teams/support and brokerage / case managers).

Take-up of HMRs could also be increased through ‘train-the-case worker’ programs with occupational therapists, psychologists, social workers and mental health nurses involved in the management of people with a mental health illness.

With regard to Consumer Medication Information (CMI), it was felt that printing out reams of legally necessary detail on the side effects of many mental illness medications may act as more of a negative than a positive in achieving better quality/informed usage. It would also help if there was more consistent use of CMI and it was used to manage the interaction with people suffering from mental illness:

Stakeholder comments

“If someone takes the time to ask how things are going, it provides a better opportunity to ask other questions about medication usage.”

Further Research Pointers

- *Trial use of pharmacists in:*
 - *the education and support of people suffering from depression, beyond the Orange district to other regions / jurisdictions (SANE has had preliminary discussions with the Victorian Guild for such a rollout); and*
 - *other mental illnesses eg psychosis;*
- *Trial new modes of triggering HMRs*
 - *from hospital at the time of discharge after a mental illness admission; and*
 - *working directly with community mental health case workers; and*
- *Develop packages for training the mental health workers in mental illness medication management.*

Acceptability Access Issues

This was again not seen as a major barrier.

Further Research Pointers

- *None identified.*

Ranking of Access Measures in order of Importance

- 1. Availability**
- 2. Affordability**
- 3.**
- 4. Geographic Accessibility/Acceptability (equal ranking)**

Australian Mental Health Consumer Network (AMHCN)

Date: Monday, 6 June 2005

Interviewee: Ms Helen Connor – CEO

Background Information

The Australian Mental Health Consumer Network, established in 1996, is a national, representative mental health consumer voice funded by the Department of Health and Ageing.

Through its advocacy role and valuing of consumer expertise that enables full participation in Australian society, it supports the National Mental Health Strategy which aims to:

- promote the mental health of the Australian community;
- where possible, prevent the development of mental disorder;
- reduce the impact of mental disorders on individuals, families and the community; and
- assure the rights of people with mental illness.

It is estimated that mental health problems and mental illness will affect more than 20% of the adult population in their lifetime and between 10-15% of young people in any one year.

Many will recover spontaneously; the vast majority can be treated and will fully recover; a smaller number of people will experience longer periods of distress and disability.

Despite the suffering and the great personal and financial costs resulting from mental illness, the community has not always recognised the needs of people with a mental illness, or their right to live independent lives.

In the past, the more severely affected people were isolated and treated in psychiatric institutions, and had little opportunity to participate in the life of the community. Recently, things have changed and, although some people with severe mental illness will still require hospitalisation, the emphasis is now on treating and supporting people with a mental illness in their own communities.

People with a physical illness evoke community concern and sympathy, and we readily recognise their needs. People with a mental illness are not usually so fortunate.

For community-based treatment of people with an ongoing illness to be effective, they may need access to a range of different services:

- specialised mental health services that recognise their rights and respect their dignity;

- general medical services, housing, accommodation support, social support, community and domiciliary care; and
- income security, employment and training services that can all have a significant impact on the capacity of a person with a mental illness or psychiatric disability to live in the community, free from discrimination and stigma.

Ms Connor indicated that one in five Australians suffer from some form of mental illness across all age groups (as defined by ICD10 Codes of Disease). This group tend to be heavy users of medications with many people requiring multiple medications to treat/control their condition.

It needs to be understood, however, that many people with mental illness:

- do not always realise or accept that they have an illness at all;
- often resent being under (doctors') orders to take medication(s) – with the implication that their purchase of it is commonly a begrudging one; and
- do not always understand the need/importance of continuing to take their medication(s) at the required dosages to keep their illness under control.

Affordability Access Issues

This was cited as a key issue with lack of disposable income and cash flow problems causing many patients to delay or lapse with buying prescribed medications.

For part-time worker it could be a “real struggle” to afford the \$28 a script payable at the general rate (PBS) until the threshold was reached and the amount became \$4 a script.

Stakeholder comments

“My doctor went berserk when he found out I was dispensed a generic version of the drug I was prescribed....the pharmacist checked their book and advised me they were the same.....I didn't appreciate them acting as if they knew better than my doctor.I know of three different psychiatrists that insist on the use of non-generics.”

Further Research Pointers:

- *none identified*

Accessibility Access Issues

This was not felt to be an issue.

Further Research Pointers:

- *none identified*

Availability Access Issues

Many patients/consumers with mental illness tend not to ask too much about the drugs they are taking or what information services are available – so they are generally not well informed about the impact of the medicines on their well-being. In addition, a significant proportion has low literacy levels which make it difficult for them to understand on-pack/in-pack medication instructions or usage information. It is therefore important that pharmacists make a real effort to advise them and asking more questions about the patient's condition in a pro-active manner – including whether they have taken the medication being dispensed before.

It was felt that whilst many pharmacies provide CMI printouts, many still do not. Because mental illnesses are often transient and do not regularly use the same pharmacy, they may not always have access to this service/information.

Ms Connor was positive towards a possible roll-out of the 'Orange' Trial (see SANE interview) and extending its implementation into areas of mental illness beyond depression.

Further Research Pointers:

- (see SANE interview summary)

Acceptability Access Issues

This was rated the number one issue.

Ms Connor believed that to improve the acceptability of pharmacy services to the mentally ill there was a real need for pharmacies to be more aware of (and sensitive to) the anxieties/fears people often have about going to new/unfamiliar places and also changing medications.

Pharmacies need to realise that their professional atmosphere, bright lights, often 'slick' modern décor and well presented staff can be very intimidating/confronting to many who suffer from mental illness.

Stakeholder comments

“ a more gentle and welcoming approach is what is needed to help them feel more comfortable about entering a pharmacy environment ”.

It was felt issues relating to medication side effects could also be communicated better.

Further Research Pointers:

- none identified

Ranking of Access Measures in order of importance:

- 1. Acceptability**
- 2. Affordability**
- 3. Availability**
- 4. Accessibility**

Disability Perspectives

National Council on Intellectual Disability (NCID)

Date: Wednesday, 8 June 2005

Interviewee: Mr Mark Pattison, Executive Officer

Background Information

The National Council on Intellectual Disability (NCID) is the national association representing people with intellectual disability and their families in Australia. It was established over 30 years ago by parents and friends to make the Australian community one in which people with intellectual disability are involved and accepted as equal participating members.

The Council is the recognised national peak body with the single focus on intellectual disability ie, its actions and priorities centre on issues that affect the lives of people with intellectual disability and their allies. NCID's State based Agency members/affiliates include:

- Developmental Disability Council of Western Australia Inc. (DDC);
- IDSC - South Australia;
- NSW Council on Intellectual Disability;
- People First ACT;
- Parent to Parent Association of Queensland Inc; and
- Victorian Advocacy League For Individuals With Disability (VALID).

Affordability Access Issues

Across the board, intellectually disabled people tend to be high level users of prescribed medications, with most having a pension or health card to assist with costs of purchasing. Here, the main discussion around affordability centred on situations where intellectually disabled children are involved and specifically, the issue of eligibility/non-eligibility of people (carers/parents/guardians) to receive a Carers Pension or Carers Allowance and subsequently have possible access to Healthcare Card entitlements.

Lack of financial support/concessions for medications needed for 'non-mandated' conditions can lead to real cash flow/affordability problems for families, particularly where there is more than one child requiring treatment of some kind.

A further point raised is that bulk-billing is usually not offered by GPs and specialists in regional areas.

Further Research Pointers:

- *None apparent*

Accessibility Access Issues

This was not perceived as a problem. It should be noted that Mr Pattison lives in a regional NSW town which has two pharmacies.

Further Research Pointers:

- *None apparent*

Availability Access Issues

Way beyond the affordability of medication in terms of significance was access to information and advisory services, particularly for parents/carers of children suffering from an intellectual disability. Mr Pattison believed what these people most need/want is for pharmacists and GPs/specialists to spend time becoming involved as “partners” in assisting them with the planning, control and management of their childrens’ condition. Not just in the practical sense of achieving the best possible medication outcomes with minimal adverse side effects, but also the psychological sense of:

- helping patients to cope better eg educationally and socially; and
- helping parents/carers to have the knowledge and understanding needed to cope with changeable patient behaviours and to feel that they are more “on top of the situation” . This in turn reduces their stress and anxieties and improves both family cohesion and their overall ability to respond to situations.

Further Research Pointers:

- *None apparent*

Acceptability Access Issues

It was felt that the sensitivities of pharmacies towards carers and patients were “pretty good.” Mr Pattison saw the physical layout of pharmacies as a factor here, particularly for children who exhibit ‘difficult behaviour’. Where aisles are narrow and space is cramped, they tend to be much harder to control/keep happy than in places which are more open and feel less crowded.

Further Research Pointers:

- *None apparent*

Ranking of Access Measures in order of importance

- 1. Availability**
- 2. Affordability**
- 3. Acceptability**
- 4. Accessibility**

Physical Disability Council of Australia (PDCA)

Date: Tuesday, 14 June 2005

Interviewee: Ms Sue Egan, CEO

Background Information

The PDCA is a National Peak Disability Organisation funded by the Federal Government which represents the interests and views of people with physical disability across the nation. It is affiliated with some 700 other disability bodies Australia wide, has around 2500 members and is 100% run, controlled and represented by disabled people.

By the year 2010 it is forecast that the number of people with physical disabilities in Australia will be approaching 28% of the total population.

Approximately 50% of people suffering from a physical disability are felt to be heavy users of prescription medications and 50% moderate users. No-one is on 'no medication'. The types of medications used vary widely and encompass everything from anti-depressants, antibiotics and pain relievers to drugs for fluid reduction and control of muscle spasms.

Affordability Access Issues

This was seen as a major issue.

An underlying factor here is that the condition of many physically disabled people limits their ability to work and their earning capacity. This in turn can affect their entitlement to, for example, a Mobility Allowance, and their subsequent eligibility for a Healthcare Card. Whilst the Disability Support Pension financially assists many people in this group, Ms Egan cited the plight of one member who recently said to her that they still end up paying \$100 a month before the PBS Safety Net threshold kicks in.

Whilst a variety of cheaper generic brands are available, there is a belief that generics often do not work.

Further Research Pointers:

- *None apparent*

Accessibility Access Issues

This was also viewed as a major issue due to peoples' limited physical mobility.

It is common for people with a physical disability to have difficulty (or a total inability) to drive a car, with the result that many must rely on family/friends for transport to doctors/pharmacists, use costly taxis, or take public transport. With buses and trains, Ms Egan mentioned that a common problem was that access to individual elements of these services was possible at some points of a 'broken' journey, but not at others.

In rural and remote areas, where public transport services can be more limited than in cities and people must often travel greater distances to visit prescribers and dispensers, the difficulties are magnified even more.

Lack of equitable access to the built environment also tends to disadvantage people with physical disabilities in most aspects of their lives. Inaccessible premises with flights of stairs and no ramps often mean that they are unable to access health services such as doctors, dentists, physiotherapists and specialised services (e.g. women's health centres). It was felt, however, that pharmacy outlets were generally "pretty good" in this regard.

Ms Egan felt that while not many people knew about 'e' pharmacies, purchasing over the internet was a real plus in improving access to prescription medications and reducing per item costs by around 50 cents. This method of purchase requires posting off the original copy of the prescription and then receiving goods back by mail. It was also believed that being able to 'phone order' repeat prescriptions to GPs and have pharmacies 'home deliver' medications was happening in some parts of Australia and needed to become far more prevalent.

Further Research Pointer:

- *Proportion of prescriptions purchased over the internet or via phone delivery and the availability of these different purchasing channels.*

Availability Access Issues

The key point raised here was that whilst pharmacy information/advisory services are improving all the time, their availability is not widely known by a lot of consumers.

Stakeholder comments

"There's a real need for pharmacists to advertise these information sharing services and increase peoples' awareness of their very existence.....a brochure outlining all the various things offered would be really helpful.....possibly even a generic TV campaign could be used."

Ms Egan had never heard of Home Medication Reviews (HMRs) before this interview. She was most positive about their role for the physically disabled and the elderly once it was explained. CMIs were felt to be "useful but not widely used". Comment was also made that few pharmacies seem to keep a record of their customers' prescribed medications [HMA note: this is clearly incorrect but suggests the need for a promotional campaign describing the support to maintaining patients' medication history that is provided by community pharmacy software].

Further Research Pointers:

- *None apparent*

Acceptability Access Issues

This was generally not seen as a key issue:

Stakeholder comments

“I don’t think pharmacies are particularly intimidating to the physically disabled....although people from CALD backgrounds may encounter some degree of language or cultural difficulty”.

Ms Egan mentioned that some pharmacies could do more to explain the potential side effects of certain medications to relieve patient/user anxieties over not knowing if they were having a ‘normal’ reaction.

It was also re-emphasised that increasing the use of modern communications to improve consumer access to pharmacies would be welcomed eg phone advice and phone ordering of medications.

When asked if ‘alternative (non-prescription) medicines’ were used by the physically disabled, Ms Egan confirmed they were for certain conditions.

Stakeholder comments

“ These days, people are moving more and more towards over-the-counter ‘health products’ that promote personal wellbeing and prevent conditions occurring....the traditional way has been for GPs to treat conditions once they’re apparent.”

Further Research Pointers:

- *None apparent*

Ranking of Access Measures in order of importance

1. **Affordability / Accessibility** (equal ranking)
- 2.
3. **Availability / Acceptability** (equal ranking)
- 4.

Indigenous Perspectives

Overview of Indigenous Issues

Date: 21 June 2005

Interviewee: Dr Richard Murray

In conducting this interview with Richard Murray, HMA specifically sought to identify indigenous issues which had arisen since the 1997 Keys Young Report and the subsequent introduction of supply of PBS medicine to remote area Aboriginal and Torres Strait Islander primary care Health Services (ATSIHSs) under Section 100 (S100) of the National Health Act, an initiative to improve health outcomes among ATSIHS clients by improving access to PBS medicines.

Background Information

Under S100, approved ATSIHSs in remote centres and other remote areas (as defined by the ARIA index) are now able to order PBS medicine in bulk through local pharmacies, and supply them as needed to patients from an on-site dispensary at the ATSIHS. The scheme does not utilise the direct pharmacist-to-client relationship which applies with usual PBS dispensing arrangements and operates with varying service delivery models that include an 'on-site pharmacist' and visiting and supply arrangements with a community pharmacist, hospital pharmacist or both; the usual co-payment associated with PBS medicine is not charged; and the usual necessity for patients to show/produce a Medicare/health benefits/concession card is effectively waived.

A 2000-2001 Service Activity Report⁶² provides the following key statistics on 124 surveyed respondents of the 129 ATSIHSs operating throughout Australia:

- 51 of the 124 ATSIHSs (often referred to as AMSs) are located in 'remote' and 'very remote' locations (ARIA index above 5.8). This means that Australia-wide, 73 'highly accessible, accessible and moderately accessible' ATSIHSs (including eg in Darwin) do not benefit from current S100 legislative provisions;
- ATSIHSs employ 2300 'full time equivalent' paid staff and a further 200 who are not paid by the Services – of the 2300 health service funded positions, 1500 (67%) were held by Aboriginal or Torres Strait Islander people;
- most services (70%) had access to medical specialists/allied health professionals who were not paid by the service;
- approximately 1,210,000 episodes of health care were provided to Aboriginal and Torres Strait Islander clients in 2000 - 2001 via AMS outlets. This confirms the vitally important role AMSs play in offering this group access to medicines, particularly when one recognises that it is extremely rare for GPs working in general practice to see/treat indigenous patients.

⁶² SAR Key Results for the years 1998-2001 <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-oatsih-pubs-sar.htm>

A 2003 Evaluation⁶³ of the abovementioned Section 100 arrangements delivered 44 recommendations for Government to consider in deciding future policy directions. These are still being reviewed and awaiting a policy response. The evaluation report did conclude that–

“...The program resulted in increased access to medicine in all jurisdictions. There was increased access to oral hypoglycaemics, ACE inhibitors, asthma medicine and acute medicines. These are all used to treat conditions that are particularly problematic in the Aboriginal and Torres Strait Islander community.....Overall, S100 has been a very successful program and all respondents supported its continued funding.....The main tension is in determining whether the S100 arrangements should retain their relatively narrow focus and additional support should be provided from complementary initiatives such as the support allowance, OR whether the program itself should be expanded.”

With respect to the above situation on future policy, Dr Murray said,

Stakeholder comment

“There is strong general consensus that continuing to improve access to medicine for indigenous communities is a prioritythe best means of achieving this is what is still being developed by the processes in place. The barriers to access and the areas needing improvement are known. It’s now a matter of policy implementation. It would appear that the Government will respond in one of two ways - either by introducing an individual entitlement card or by extending S100 supply to include rural, regional and urban areas. Given the positive evidence of remote AMS S100 operations (eg in Alice Springs) being able to be successfully applied to non-remote areas , extending supply is in my view the preferred option...it also has the benefit of having no stigma attached.”

Trialling and assessment of different AMS service delivery models is ongoing with a specific view to further improving Quality Use of Medicines (QUM).

Dr Murray cited delisting of certain medications from the PBS (eg anti-fungal treatments for tinea) as having a disproportionate impact on aboriginals due to so many of them living in climates where fungal conditions are common. He also mentioned that based on a new mechanism first trialled for Palliative Care drugs, lobbying was continuing for providing improved access to non-PBS listed drugs which were particularly useful in treating high-incidence indigenous ailments.

There is a confluence of reasons explaining why indigenous communities have traditionally exhibited the highest incidence of disease of any group in Australian society. Key among them is that they are the poorest, most geographically isolated and highest ‘under-utilisers’ of medicines - people who also suffer from discrimination.

⁶³ RFT 102/0203 Evaluation of PBS Medicine Supply Arrangements for Remote Area Aboriginal Health Services Under S100 of the National Health Act. – Co-operative Research Centre for Aboriginal Health and Program Evaluation Unit*, University of Melbourne (*formerly Centre for Health Program Evaluation) <http://www.seniors.gov.au/internet/wcms/publishing.nsf/Content/health-pbs-indigenous-eval>

Future Research Pointers:

- *Scope for extending current S100 (remote area only) arrangements to also apply to rural and urban areas.*
- *Creation of a special list of medications applicable to 'high incidence' indigenous ailments (based on the recently introduced Palliative Care model).*

CALD Perspectives

Federation of Ethnic Communities' Councils of Australia (FECCA)

Date: Wednesday, 25 May 2005

Interviewee: Karen Green, National Prescribing Service Community QUM Project Manager

Background Information

FECCA is the peak National body representing multicultural and ethnic councils across Australia and acts a Secretariat for its 21 member organisations.

Looking into healthcare issues is one of the organisation's major priorities – as is recently evidenced by its joint involvement in a Community Quality Use of Medicines (CQUM) project with the National Prescribing Service (NPS) over the past 15 months.

This multiculturally based study has involved using face-to-face interviews and consumer focus groups in four Australian states to gain responses from four specific ethnic community groups; namely, Chinese, Greek, Italian and Vietnamese (potentially this project will also be extended to cover Arabic and newly emerging groups.)

Evaluation of the findings so far has been done by the NPS and one of the outcomes has been the March 2005 production of the *Medimate* bilingual booklet to assist consumers in documenting and keeping track of doctor visits and medicines being prescribed for their use. *Medimate* has been produced in each of the four language/cultural groups examined through the CQUM project.

Ms Green's assessment of the factors affecting access to prescription medicines provided below should be viewed in the light of the specific point she made that, "the situation differs significantly between different ethnic groups. It is not possible (or meaningful) to simply group everyone together under the one banner of Culturally and Linguistically Diverse (CALD)".

Affordability Access Issues

This was cited as a key issue – most particularly for older generations whose earning capacity has diminished and whose propensity to require prescription medication has increased with the ageing process.

Cost issues are exacerbated by confusion around generic medicines and labelling – problems compounded by language difficulties of people from CALD backgrounds. Some are also fearful of the whole system: language barriers cause people not to ask questions ('they don't want to be seen as stupid') and, as a result possibly do not access their medicines.

Further Research Pointers

- *None identified.*

Accessibility Access Issues

Discussion here again centred on older people from CALD backgrounds. They often no longer drive and are reliant on their children or relatives to take them to doctor appointments or to visit pharmacies. Where language barriers and cultural preferences exist, this can result in patients travelling considerable distances to access a pharmacy run by a person of their own nationality.

It was noted that there are lists of GPs that speak more than one language but no equivalent for community pharmacists.

Further Research Pointers:

- *Develop a list of multi-lingual community pharmacists and develop framework for publicising.*

Availability Access Issues

People from first generation CALD backgrounds and experiencing language difficulties often do not read material if its not in their own language. Some people are illiterate in their own language.

Further Research Pointers:

- *Scope for developing CMI in languages other than English and distributing via the internet.*

Acceptability Access Issues

This area emerged as the number one barrier – primarily due to cultural differences, some predisposition towards continuing to use traditional (or ‘old country’) medicines or health techniques and people having a limited command of the English language.

Whilst assimilation and understanding of English progressively increases among second and subsequent generations, cultural differences are still passed down. Stoicism, especially among Greek men, is seen as a sign of strength and often results in them not using prescription medicines. The Chinese view taking medicines as a sign of weakness. Italians often see injections as a superior mode of delivery to oral or tablet medication. With newly emerging communities, Southern African women, for example, are not in the habit of going to doctors or admitting to medical problems. With Japanese women, traditional gender issues prevent them from, for example, being seen buying sanitary napkins.

There is a strong tendency for ethnic communities to trust and ‘see doctors as a god’ and they expect to be ‘told the medical answer to their problem’ – not to have to ask questions. The limited quality time doctors have available to spend on individual patients often undermines this expectation and causes patient dissatisfaction.

Where language barriers exist that affect understanding of literature or professional advice from doctors or pharmacists, the acceptability of the quality of medical service is further diminished. This interaction issue correlates to the very real emotive barrier of

people from CALD backgrounds not wanting to ask questions that might make them appear ‘stupid’ or inadequate. It is also a key reason among the elderly from a CALD background who often ‘fear’ and are confused by Australia’s overall healthcare system.

It is very difficult for older members of communities from CALD backgrounds to accept what they do not understand (or wish to embrace).

Further Research Pointers

- *None identified.*

Ranking of Access Measures in order of importance

- 1. Acceptability**
- 2. Quality of Medicine/Service**
- 3. Physical Availability**
- 4. Affordability**
- 5. Geographic Accessibility**

National Prescribing Service (NPS)

Date: Monday 30 May 2005

Interviewee: Ms Jennifer Davis, CQUM Project Officer

Background Information

NPS works with health professionals, government, industry and consumers to improve the health of all Australians through Quality Use of Medicines. The variety of programs and services NPS provides are independent, evidence-based and focussed on quality. A key aim of these is to increase consumers' use and free access to credible information resources on medicines and to also help to improve their skills in communicating with health professionals.

It should be noted that a primary objective of the NPS is to focus its attention on delivery of services *after* the prescription has already been filled and *after* any barriers to accessing a medicine have been hurdled by the consumer ie their focus is on QUM once medicines are accessed, rather than barriers to access.

Major consumer groups being targeted by the NPS include:

- parents of young children;
- senior Australians;
- people with chronic illness;
- rural communities;
- indigenous communities; and
- multicultural/ethnic (CALD) communities.

Initiatives of the NPS include:

- 'Medicines Line' which provides consumers with direct telephone access to pharmacists and independent, accurate information on eg. prescription medicines, over-the-counter medicines, herbal and natural therapies.;
- distribution of information on medicines via easy-to-understand leaflets on a range of medicines;
- 'Medicines Talk', a quarterly magazine produced by consumers, for consumers with consumer-friendly information plus news and stories about medicines.

The NPS Community Quality Use of Medicines (CQUM) program launched in January 2004 is also being developed in partnership with the Consumers' Health Forum and other consumer groups. This has specifically involved our interviewee, Ms Jennifer Davis, in an ethnic community research project that (to date) has targeted Chinese, Cantonese, Vietnamese, Greek and Italian communities in Australia (in association with FECCA). Findings have resulted in the production of the multi-lingual 'Medimate' booklet - a consumer-friendly, practical guide to help people (particularly older citizens) find, understand and use information about medicines more effectively (this is now available in English, Italian, Greek, Vietnamese, Chinese.)

After interviewing a number of individual consumers and ‘key informants’ for the FECCA project, that included health professionals and community leaders, the following barriers emerged as real factors affecting consumer access to medicines – primarily among the elderly. (they closely reflect those cited in the interview conducted with Ms Karen Green at FECCA):

- (1) Language difficulties and cultural differences often impede communication with health professionals and CALD peoples’ understanding of the safe and effective use of medicines. Literacy/lack of education is also a factor here and the overuse of medicines was a finding linked to a general lack of knowledge regarding the quality use of medicine. It should be noted that many older immigrants have come from quite poor, rural backgrounds where access to medicines and advice was limited.
- (2) There is evidence to suggest that people feel uncomfortable about asking questions of doctors and take a relatively passive role in dealing with health professionals, who they generally hold in high esteem. Beyond not feeling equipped to ask the right questions and usually seeing it as a doctors’ role to ‘tell them’ the medical answers, there is an issue among Asian communities in particular that it is disrespectful to query what they are told by doctors/pharmacists.
- (3) The use and belief in traditional ‘old country’ medicines/treatments is still prevalent eg herbs are commonly used by Greeks and Italians. ‘Cupping’ is a common practice among Vietnamese. Acupuncture is widespread among several groups, especially Chinese.

Ms Davis suggested that a major role of NPS services and literature aimed at ethnic groups would be to encourage people to be less passive and more proactive in their dealings/relationship with health professionals. This includes developing their awareness that doctors are *accepting* of patients asking questions.

Action on Disability within Ethnic Communities (ADEC)

Date: Wednesday 15 June 2005

Interviewee: Ms Licia Kokcinski, CEO

Background

Predominantly state funded, Action on Disability within Ethnic Communities (ADEC) is a Victorian community based organisation which represents the rights and needs of people of non-English speaking background who have any kind of mental or physical disability and their carers. ADEC provides advocacy, information, referral, education, training and consultancy to individuals and assists with linking people to services available to meet their needs.

As well, it offers training programs to service providers, community organisations and government departments and is involved in consultancy and specialist policy development programs targeted towards specific issues eg. psychiatric services.

Ms Kokcinski cited that each year they deal with 30-40 different language groups, see 300-400 carers and provide one to one assistance to around 250 people with a disability across all age groups and socio economic backgrounds.

Those with a disability tend to be very heavy users of prescription medications with most (75%) taking multiple (5 to 10) medications per month. Additional over-the-counter products are also regularly used eg pain relievers.

A key insight provided about ethnic/CALD people suffering from a disability is that they generally display a very high level of respect for the authority of medical professionals and place a great deal of faith in the advice they receive from both doctors and pharmacists. This explains to a large degree why they:

- tend to accept what they are told and not to ask too many questions; and
- prefer to use 'professionally recommended/endorsed' branded products prescribed over generic alternatives;

Affordability Access Issues

Whilst this was seen as a significant issue, Ms Kokcinski indicated that most disabled individuals and carers that ADEC sees seem reasonably satisfied with the PBS system and the level of access to financial subsidisation delivered via disability pensions and carer benefits.

Pricing of medications does not appear to be a topic they discuss much or have a problem with. It was felt that this group's very high medication usage probably takes them past the safety net threshold quite quickly to dramatically reduce per script costs.

Further Research Pointers:

- *none identified*

Accessibility Access Issues

Whilst unable to comment on the situation in rural and remote areas, physical access to prescriber/dispenser services in suburban environments is not an issue/problem.

Further Research Pointers:

- *none identified*

Availability Access Issues

This was clearly the number one issue discussed and language difficulties emerged as by far the biggest barrier to CALD patients/carers understanding and having access to professional pharmacy advice and information services.

Stakeholder comments

“Some pharmacists actively employ bi/multi-lingual staff and that is to be applauded.....others can be rude and fail to treat people whose command of English is not that good as valued customers.....the personality of the pharmacist is critical to developing a friendly, respectful relationship and rapport that improves communication.”

Ms Kokcinski was unaware of HMRs and believed that CMI printouts in high level English really were not the answer to medication usage information.

Stakeholder comments

“ Everyone needs to realise that there are often low levels of literacy and formal education among certain ethnic communities, particularly newly emerging ones. They have a very high dependence on pharmacies ‘telling them’ what to do in a way they can comprehend. Somehow we need to get better translation/multi-lingual services in place.”

Word-of-mouth and workshops conducted within specific groups is often the most effective way for people to become aware of services available and understand them in their own language.

Further Research Pointers:

- *none identified*

Acceptability Access Issues

It was thought that the expectations of people in this group “aren’t that high” regarding the quality of pharmacy services/products offered. Many newer arrivals to Australia come from oppressed, war-torn countries so that now ‘anything is better than what they had’. Language is again the key barrier to them feeling equipped to ask any questions let alone the ‘right’ questions – so they are very accepting of what they are told by both prescribers and dispensers of medications.

Further Research Pointers:

- *none identified*

Ranking of Access Measures in order of importance

- 1. Availability** (multi-lingual information)
- 2. Affordability**
- 3. Acceptability**
- 4. Accessibility**

Homeless Perspectives

Australian Federation of Homelessness Organisations (AFHO)

Date: Thursday, 26 May 2005

Interview: Jack Quinane, Executive Officer

Background Information

AFHO is the peak National body for homelessness organisations and people experiencing homelessness. It is 85% government funded and represents some 1300 *Supported Accommodation Assistance Program* (SAAP) funded services across the states and territories.

According to the 2001 Australian Bureau of Statistics Census, Australia has a homeless population of 100,000 - with Queensland and NSW both having around 25,000 (or 25% of the total). Around 8% of homeless people are indigenous. One in three homeless people have a child – 88% under the age of 12.

Mr. Quinane put the seriousness of this social problem into clear perspective when he said, “On any given night in Australia, no less than one in 200 people are homeless. This is the equivalent of the devastating after effects of four Cyclone Traceys, 40 Canberra Bushfires or 100 Newcastle Earthquakes.”

He also made clear that homelessness is an extremely complex issue and that factors causing it vary significantly across different groups. Custom and practice define these as -

- ‘Youth;
- Women; and
- General.’

The following key points can, however, be made:

- There is a direct correlation between homelessness and poverty. This in turn has a direct bearing on affordability being a major access barrier to prescription medicines and healthcare generally.
- Medicine affordability is often further impinged upon because they are often left with little disposable income. Homeless people who are ‘boarding’ having to spend a large proportion of their money on board. In situations where women are quickly forced to escape a domestic violence situation, they commonly have to leave behind their belongings/assets – they then have the cost of resetting themselves up from scratch.
- The health needs of homeless are higher than the rest of the population, including substance abuse, disabilities and mental health disorders (Source: FACS: *National Homelessness Survey*).
- Their plight is exacerbated by them having to deal with the trauma of events that caused them to become homeless in the first instance eg women/children who have been victims of domestic violence or sexual abuse.
- Often they have no personal transport, no telephone and no fixed address – moving around a lot also makes it harder for them access support services

because of a lack of documentation. Many do not use a regular doctor, pharmacist or clinician. Many also feel uncomfortable about using mainstream services.

- Homeless people, especially under the age of 18 (without a driver's licence) often have difficulty with proving their identity and/or income to access concessions.

At this point in the HMA study, no meaningful observations can be tabled on the existence (or order of importance) of barriers each of the homeless groups face in accessing prescription medicines. Further work is involved in talking to SAAP service providers.

Further Research Pointers:

- *Little is known regarding the extent of homeless peoples' use of prescription medicines.*
- *Investigate the extent to which changes to tenancy arrangements for public housing (especially in NSW) may increase the risk of marginalised people being 'pushed' into homelessness.*
- *Scope for establishing a 'medicines' funding pool for homeless people, to be administered by SAAP providers.*

An Overarching Perspective

Consumers' Health Forum of Australia (CHFA)

Date: Wednesday, 15 June 2005

Interviewee: Ms Yvonne Solly, Community QUM Officer

Background Information

It should be noted that this interview was conducted for the specific purpose of identifying '**new barriers/issues**' affecting consumer access to medicines which **have not** been apparent from/specifically addressed in other stakeholder consultations held to date and which emanate from field work Ms Solly has recently been involved in. This was consultation research with CHF members contracted by the National Prescribing Service.

Affordability Access Issues

- Foster parents/carers (who may be simultaneously looking after several children) can be faced with a lot of 'out-of-pocket' treatment/medication expenses due to them not being entitled to the same concessions/benefits as parents who are caring for their own children. An example was cited of a 'foster parent' in the Northern Territory spending \$600 in one week when all six children in her care came down with a contagious illness.
- Lack of information on the 'interchangeability' of branded and generic products acts as a common barrier to consumers having the assurance they need to feel safe in using the cheaper/cheapest medication.
- Ms Solly felt that "most commonly prescribed medications have a generic version available but that pharmacists are often reluctant to offer or promote this to consumers."
- Lack of prescribers who are still offering 'bulk-billing' is a real factor in consumers not being able to afford doctor visits. There is a flow on affect from this that can mean people who do pay the full GP fee for a visit may then not have the funds needed to fill the script they've been given.
- Mention was made of people (particularly in country towns) becoming loyal to one pharmacy where their medical information/medication history is recorded and that this can prevent them from wanting to utilise a different pharmacy who may offer certain products/medications at a cheaper price.
- It was noted that the quantity of free medications available through hospital outpatient departments was reducing as a result of public hospital cost cutting measures. HMA pointed out that this mechanism of supply would be further restricted as a result of the PBS Reforms being introduced in Victorian hospitals. As result of these Reforms hospital doctors in approved hospitals must now prescribe medications using the PBS arrangements at the time of discharge, or in non-admitted services. As a result, patients co-payments (and the PBS safety net arrangements) now apply in these circumstances.

Accessibility Access Issues

- No substantive new issues were apparent, although it was mentioned that many people with chronic illnesses would welcome ‘greater harmonisation’ of services to minimise their need to visit multiple locations and providers to access their GP, specialist(s) and other professional healthcare services in order to manage their healthcare.

Availability Access Issues

- Whilst the need for improved access to (and promotion/awareness of) pharmacy information services like HMRs, CMI and the PBS ‘Medicine Line’ have been well documented from other interviews, Ms Solly took this a step further:

Stakeholder comments

“Some people don’t even know of their entitlement to claim back costs on Medicare...there’s still a lot of work to be done in furthering consumer knowledge about the whole medical system”.

Acceptability Access Issues

- With respect to the issue of consumer privacy in pharmacy environments, there are specific difficulties and sensitivities for patients who need to be accompanied on their visit by a carer/friend/family member/or interpreter (CALD situations). They are often unable to discuss personal matters with their pharmacist without their “minders” being privy to the conversation, which can be more embarrassing than a stranger overhearing.
- Illnesses which have a ‘social stigma’ often result in reduced patient uptake of filling their prescriptions. They are simply fearful of others finding out about their condition.
- Whilst the importance of doctors and pharmacists being good communicators has been covered in other interviews, Ms Solly suggested that development of their personal skills and ‘bedside manner’ with patients was so crucial to building trust relationships (and improving the consumer experience of accessing medicines) that further opportunities for professional development of doctors in this area should be considered.
- On the topic of whether ‘complementary/alternative’ medicines posed a possible threat to consumer demand for prescription medications, it was felt that the huge interest in natural/herbal products and the large amounts of money people are now spending on them suggest that they are indeed a major competitor.

Stakeholder comments

“There is strong anecdotal evidence emerging that people are actually substituting complementary medicines for prescribed ones – not just purchasing it in addition. It’s usually a bit cheaper and people sometimes feel that ‘herbal’ has to be better for your body than prescription drugs.”