

An isolated problem?

Rural communities face increasing concerns amid the squeeze on health funding.

Health Minister Sussan Ley stepped into Chemmart Pharmacy Urana in the Riverina district of NSW as part of a tour of her Farrer electorate at the end of January, tweeting that the pharmacy was “part of a local, informal but very effective care team”.

With an electorate of just under 100,000 people spread across the bulk of western NSW, Minister Ley’s experience representing Farrer since winning the seat in the 2013 election will have given her an insight into how rural healthcare works, and she marked the area out as one of her priorities when taking office in her new post.

“In being a rural and regional Member of Parliament, I’ll make sure ... to keep a rural and regional focus on health,” she told the ABC.

“We know that the [health] outcomes of people in rural Australia are generally not as good as in the cities. That’s a gap that needs to close.”

Few would argue with this sentiment, but most health ministers dish out similar platitudes and rural health is still in a state of decline. Last May’s budget saw the Government meet its modest pre-election promises to the area, but there was no additional funding assistance on offer. Proposals to increase out-of-pocket health costs for consumers would impact people in rural areas more than those in metropolitan areas, as they already have higher individual costs due to difficulties in accessing care.

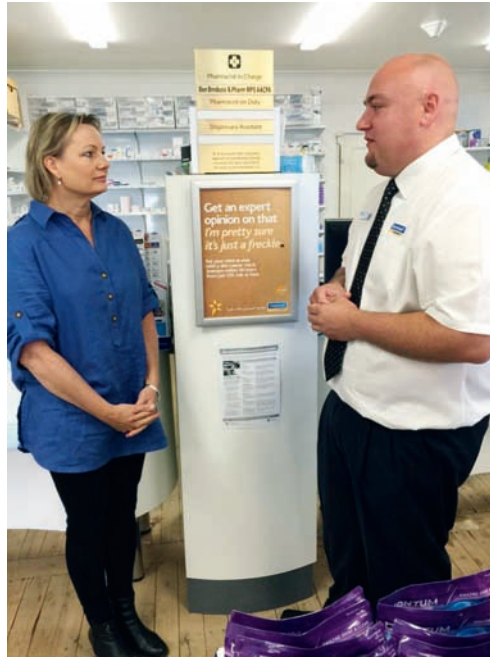
Gordon Gregory, CEO of the National Rural Health Alliance (NRHA), says rural communities are suffering from reductions in service funding.

“Both state and Commonwealth governments are cutting back where they can, and they see health as an area where they can make savings,” he said. “It’s a major concern.”

Mr Gregory says many changes to rural health are being made under the guise of “centralisation”, with an aim to provide a more standardised level of care by incorporating local services into those in larger regional centres. While this can make sense in some circumstances, it often makes it harder for many people to access the services available.

“We’re trying to say that it’s not fair, reasonable or right to rationalise services if it results in even poorer access,” he said.

“When specialised services are no longer close to home, there are all sorts of difficulties. Cancer is a good example: even though the Commonwealth Government is putting quite a lot of money into cancer, and regional cancer centres have been one of the



Health Minister Sussan Ley with pharmacist Ben Brndusic from Chemmart Pharmacy Urana.

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successes of the last five years, it’s still the case that there’s a gradient in cancer survival after diagnosis – the further you get from a capital city the worse your life expectancy after diagnosis. This is mainly because diagnosis is later, as people find it hard to get timely primary care.”

To alleviate the problem, the NRHA says a flexible spending model that can be adjusted to meet local requirements should be introduced. Crucially, this needn’t cost more than the current levels of investment.

“If you look at the service models that work in rural areas, they’re very different from place to place – and certainly different from what works best in the capital cities,” Mr Gregory said. “There needs to be flexibility of funding systems, and if it’s done correctly we can retain local services without spending more.

“It’s a false claim to suggest that to continue to provide more specialised care locally you need more money. We need to spend in a more flexible and innovative fashion and sometimes this means using health professionals working in teams to the full scope of their practice.”

Income gap

Working as part of a coordinated health team is one of pharmacy’s key long-term goals, but for now, pharmacists in rural areas have to deal with the day-to-day realities of the current health structure.

Suffering with the rest of the nation’s pharmacies from PBS decline, they also have to accommodate an estimated \$800 million shortfall in potential income when the rate at which people in rural areas use the PBS is compared with that of their metropolitan counterparts.

“The last good data we have – which is from 2006/7 – shows PBS concession card holders use around \$750 of medicines in major cities, [compared with] \$650 in inner-regional areas and \$560 in outer-regional areas,” said Pharmacy Guild Tasmanian branch Vice President Joe O’Malley, who represents Rural Pharmacists Australia on the Council of the NRHA.

“Pharmacies outside of metropolitan areas have a higher per-capita rate of healthcare concession card holders but they don’t present to the pharmacy as often as they should do.”

Mr O’Malley believes many of the problems with rural pharmacy begin with a misunderstanding of how these areas actually operate.

“One of the issues we face is the delivery of services across a non-homogenous group of delivery sites,” he said.

“Rural and regional health tends to get lumped into one basket together, but there are a number of distinct categories within that – they’re all significantly different and they all pose different delivery problems through factors such as workforce and isolation.

“For example, if you compare rural and rural indigenous care, you can quickly see that delivering health services through a pharmacy to an Aboriginal population is an entirely different proposition to delivering healthcare in rural Tasmania.”

Mr O’Malley praises many of the initiatives that have been introduced to improve pharmacy services through the 5CPA, but says that due to a lack of flexibility within the structure of the Agreement these can be hard to deliver in rural settings.

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“Look at MedsChecks,” he said. “Patients like them, and they’re not difficult to deliver, but you need a second pharmacist to be able to do them. For isolated pharmacies in small towns, it’s not feasible for them to hire that second pharmacist.

“Home Medicines Reviews are another case. There’s great evidence showing that they will benefit the patient and save the health system money, but in outback Australia it’s very difficult to deliver HMRs because of the isolation factor.

“The present funding arrangements don’t allow for exceptions or hybrid arrangements that would make these services more deliverable.”

Outback perspective

Despite the challenges, the news from rural Australia is not all doom and gloom. At the Urana pharmacy visited by Minister Ley, pharmacist Ben Brndusic describes a situation of cooperation among local health providers that could act as a model for how many would like the health service to operate.

“We have a wonderful GP, a great MPS hospital and a good community health network,” Mr Brndusic said.

“We all work together very well and are happy to share ideas. It’s a very effective, streamlined team and I feel that my voice is listened to at every stage.”

However, Mr Brndusic acknowledges that he is fortunate to work alongside a GP who is not only keen to collaborate, but is also full-time and committed to bulk-billing.

This is not the case in many rural areas and while the success of Urana’s health team is to be lauded, it is, as Minister Ley noted in her tweet, organised on an “informal” basis.

Mr Brndusic says this description fails to do justice to the professionalism with which he and his colleagues carry out their duties, but admits it would be better if the system operated within the confines of an officially recognised structure.

As the sole pharmacist in what he describes as “probably the smallest and remotest Chemmart in Australia”, he says the backing of the major pharmacy group allows him to provide a range of services equal to that in any metropolitan pharmacy.

Health checks, skin checks, HMRs and sleep apnoea services are all available at Chemmart Urana, with pharmacist vaccinations likely to come, but Mr Brndusic believes he can offer more.

“Continued dispensing, in particular, is something I’d like to see the Government talk to the Guild about,” he said.

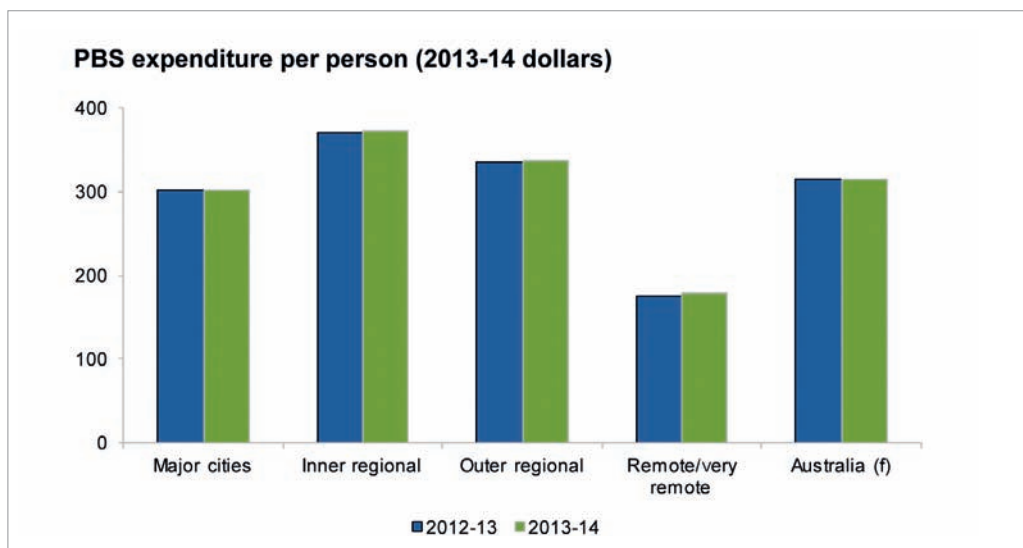
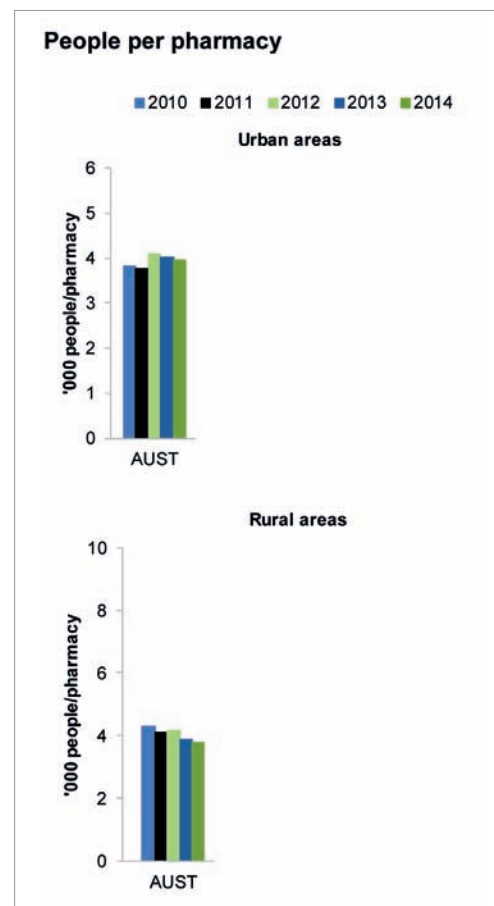
“It can be frustrating to chase scripts if for some reason the doctor isn’t here – especially when the patient has been on a drug for a very long time. The local doctor now works five days a week but previously it was just two. It was a big problem and sometimes I just couldn’t help people when the doctor wasn’t there.”

A long-term Liberal Party supporter, Mr Brndusic is hopeful that Ms Ley’s appointment can begin a new era of improved understanding of how to meet the health needs of people in rural areas.

“I think the industry will be really happy with Minister Ley,” he said.

“She listens, she understands the numbers, and she’s a compassionate person. Hopefully,

we can get to a point in the next Agreement that is favourable for the Government and for pharmacists. It would be nice to have some certainty for a change.” ^{RP}



Source: Department of health.

Greater scope for rural pharmacists?

Early last year, the NRHA released a discussion paper calling on the Government to bolster the number of pharmacists in rural areas to improve the supply of PBS medicines, and for pharmacists in these areas to have additional responsibilities.

Specific areas the discussion paper listed for consideration were:

- Professional medicine reviews – with a view to allowing rural pharmacists to provide reviews

- such as HMRs and MedsChecks in a wider variety of settings.
- Review of arrangements related to Section 100 medicines supply to Aboriginal Health Services (AHSs) and review of the additional arrangements related to pharmacists visiting and advising AHSs.
- Enhancing opportunities and incentives for young pharmacists to work in rural and remote areas.

- Enhanced reporting of pharmacist labour force data by remoteness.
- Enhanced reporting of all the PBS and Section 100 medicines in such a way as to be able validly to compare the volume of dispensing/supply across the various regions of Australia. ^{RP}

For more information visit: www.ruralhealth.org.au.