



The PHARMACY GUILD of AUSTRALIA



Position paper on improving access to PBS medications for Aboriginal peoples and Torres Strait Islanders

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1. Executive summary

'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

The implementation of Section 100 (s.100) medications for remote area Aboriginal Health Services (AHSs) has completely revolutionised access to medications on the Pharmaceutical Benefits Scheme (PBS). It represents one of the most substantial positive developments in remote Aboriginal health service delivery for many years. Already anecdotal reports from participating AHSs indicate improvements in health outcomes for Aboriginal people as barriers to access are reduced.

However, the situation in Aboriginal health which required the implementation of s.100 exists throughout Australia – not just in remote areas. The work of improving access to PBS medications remains only partly achieved.

Parties to this position paper have developed a model for non-remote access which retains the essential features of s.100, including one stop-shop, free of charge access to medications provided in a culturally appropriate setting. Essential points of difference between the current s.100 model and the proposed model are:

- the addition of the capacity for AHSs to write prescriptions that could be filled at a community pharmacy without a co-payment being charged;
- payment to the community pharmacist of the full dispensing fee per item as they receive when dispensing to all other Australians
- significant increases to funding for implementation and on-going support to best address the need for quality use of medicines.

This model could be implemented through Section.100 of the National Health Act 1953. This section of the Act allows the Minister to make alternate arrangement other than standard ones for accessing medicines. Thus implementation could occur without the need for changes to current legislation.

It should be noted that while the proposed model represents a significant step beyond the current, remote areas only, model, it is not a complete solution. Implementation is recommended via health services specific to Aboriginal people initially, and recommends that implementation via all GPs in mainstream private practice be progressed as the next priority in medicines access.

Improving access to medicines by Aboriginal people is a major policy priority in Australian National Medicines Policy.¹ It is important that the lessons of s.100 supply through remote AHSs are applied to meet the needs of urban and rural Aboriginal communities. Such reforms are eminently affordable: bringing expenditure on pharmaceuticals for Aboriginal people up to the level of the general community would represent a less than 3% increase in current PBS outlays.

¹ National Medicines Policy 2000. Canberra: Commonwealth Department of Health and Aged Care;1999
<<http://www.health.gov.au/haf/nmp/pdf/nmp2000.pdf>> [Accessed August 4 2003]

2. Why are improvements to access needed?

2.1 Summary of Aboriginal health issues

Aboriginal peoples form the most disadvantaged group within the Australian population. As the Hon Dr Michael Wooldridge, Minister for Health, observed, 'Our single most spectacular failure as a nation has been in the area of Aboriginal and Torres Strait Islander health'.²

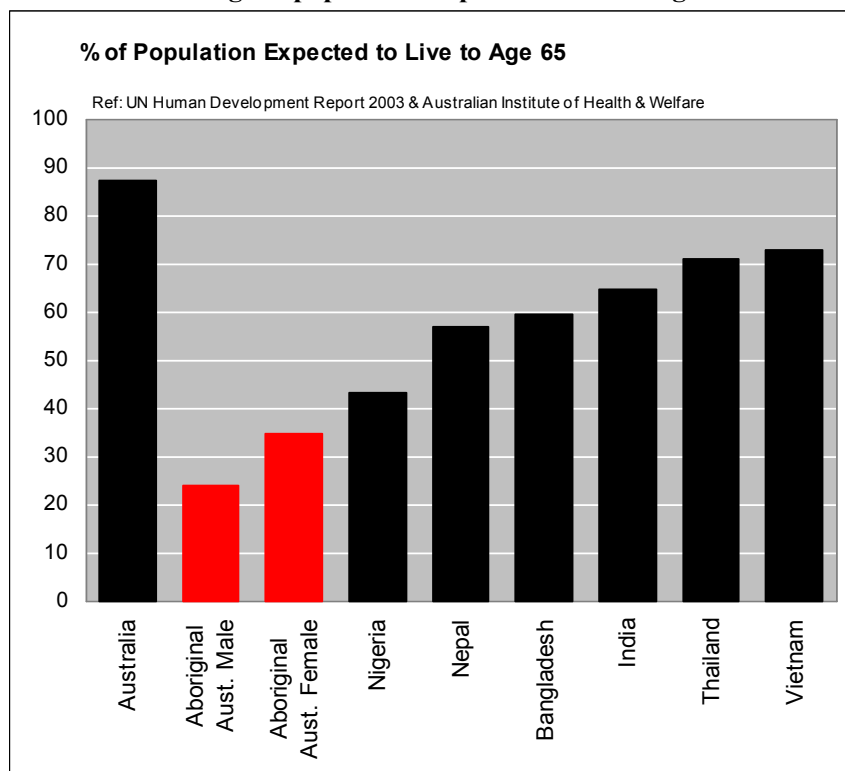
The expected lifespan of an Aboriginal and Torres Strait Islander male born in 1998-2000 is 56.0 years, which is 21 years less than the 76.6 years expected for all Australian males. For Aboriginal females, the expectation of life at birth is 62.7 years - more than 19 years less than the expectation of 82.0 years for all Australian females.³ The median ('typical') age of death for Aboriginal and Torres Strait Islander males was 50.8 years in 2000, compared to 75.5 years for non-Indigenous males. Median ages at death for Aboriginal and Torres Strait Islander females was 57.4 years as against 81.9 years for non-Indigenous females.⁴ An international comparison of the impact of these early deaths is illustrated in Table 1 below.

² Wooldridge, M. (2000). Launch of '*Australia's Health 2000*':
<http://www.health.gov.au/mediarel/yr2000/mw/mwsp200622.htm>.

³ Australian Bureau of Statistics and Australian Institute of Health and Welfare. *The health and welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, 2001. Canberra 2001. ABS Catalogue no. 4704.0..

⁴ Australian Bureau of Statistics and Australian Institute of Health and Welfare. *The health and welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, 2001. op cit

Table 1 – Percentage of population expected to live to age 65



The difference in death rates between Aboriginal people in rural, remote and metropolitan regions is much less significant than the difference in death rates between Aboriginal people in any region, and non-Aboriginal people in any region. This is illustrated by Table 2⁵ below.

Table 2. Impact of the Aboriginal and Torres Strait Islander population on the total death rate for all Australians, 1992-96 (deaths per 100,000 population)

Population group	Metropolitan	Rural	Remote	Total
Males				
Indigenous	1,500.4	1,559.0	1,879.2	1,739.6
Non-Indigenous	800.0	836.9	873.5	811.0
All Australians	804.6	845.8	1,055.1	830.5
Females				
Indigenous	983.9	1,170.2	1,418.2	1,273.9
Non-Indigenous	520.7	521.3	494.5	520.3
All Australians	524.4	528.1	708.5	535.0

Based on data for South Australia, Western Australia and the Northern Territory

⁵ Australian Institute of Health and Welfare. 2001. *Expenditures on health services for Aboriginal and Torres Strait Islander people 1998-99*. Canberra: Australian Institute of Health and Welfare and Commonwealth Department of Health and Aged Care.

The international experience on improving the health of Indigenous populations suggests that much can be achieved in relatively short periods with well-funded, coordinated programs to address health determinants and provide accessible health care. Native American populations of the US and Canada, and the Maori population of New Zealand have seen substantial gains in health status over the past generation, with expectation of life at birth now only 3-6 years behind that of the general population.⁶ It is not widely known that Australia is alone among developed nations in failing to make progress in the health of its Indigenous population over the last generation.

2.2 Access to medicines

Access to medicines is always a major plank of provision of effective primary health care and therefore must be guaranteed for this particularly disadvantaged population. In identifying better means of assuring access to needed medicine, there needs to be a strong focus on the health care needs of the Aboriginal community - rather than on 'needs' of professions or institutions. An appropriate response to these challenges has to go beyond historical professional roles and existing regulatory and administrative frameworks.

There is compelling evidence of poor uptake and barriers in access to medicines. The Keys Young review in 1997 for the Health Insurance Commission documented widespread barriers in access by Aboriginal people to health care and medicines, most of which remain relevant.⁷ A particularly striking finding was the consistency in the nature and extent of access barriers across various remote, regional and urban trial sites.

Available expenditure data suggests substantial under-use of medicines, in spite of the much higher burden of acute and chronic disease. Two recent examinations of expenditure have found per capita PBS spending for Aboriginal people to be of the order of a quarter to a third of that spent on the rest of the population.^{8,9} More recent estimates have indicated actual expenditure as \$76/capita/year for Aboriginal people compared to \$246/capita/year for non-Aboriginal people.

The National Medicines Policy includes recognition that under-use of medications must be addressed, and in particular acknowledges these substantial access barriers and evidence of under use of medicines in Aboriginal communities.¹⁰ Likewise the APAC strategic plan contains a commitment to facilitating better access to medicines for Aboriginal and Torres Strait Islander communities by next year, 2005.¹¹

There is evidence available to support the health outcomes that are available as a result of the increased use of medications combined with a model of primary health care. A study conducted in the Northern Territory showed that in those with hypertension or diabetes, rates of natural deaths were reduced by an estimated

⁶ Ring IT, Firman D. op cit

⁷ Keys-Young. Market Research into Aboriginal and Torres Strait Islander Access to Medicare and the Pharmaceutical Benefits Scheme. Report for the Health Insurance Commission, November 1997.

⁸ Deeble J, Mathers C, Smith L, Goss J, Webb R, and Smith V. May 1998. *Expenditures on health services for Aboriginal and Torres Strait Islander people*. Canberra: Commonwealth Department of Health and Family Services;

⁹ Australian Institute of Health and Welfare. 2001. *Expenditures on health services for Aboriginal and Torres Strait Islander people 1998-99*. Canberra: Australian Institute of Health and Welfare and Commonwealth Department of Health and Aged Care.

¹⁰ <http://www.nmp.health.gov.au/pdf/nmp2000.pdf> accessed May 2004

¹¹ <http://www.nmp.health.gov.au/pdf/apacplan.pdf> accessed May 2004

50% and renal deaths reduced by 57% after a mean follow-up of 3 years of ACE Inhibitor drug treatment.¹² Considering the cost of haemodialysis per patient per year is estimated to be \$78,600, the use of ACE Inhibitors, estimated at \$500 per year, is an extremely cost effective method of preventing renal failure.¹³

2. 3 Section 100 supply for remote Aboriginal health services

In a major Commonwealth initiative to address poor access to medicines by Aboriginal people, special bulk-supply arrangements for remote Aboriginal health services (AHSs) were approved in 1998 by the Minister under *Section 100 (s.100)* of the National Health Act 1953.

Under this initiative approximately 150 AHS have registered for supply through s.100, but it is estimated that this program provides improved access to approximately 29% of Aboriginal and Torres Strait Islander peoples. There is currently a review of this initiative by the Commonwealth, which should quantify the amount of expenditure that has resulted from this program.

The implementation of s.100 medications for remote area Aboriginal Health Services (AHSs) represents a breakthrough in medicines access, and is one of the most significant improvements in health service delivery for many years. Already anecdotal reports from participating AHSs indicate improvements in health outcomes for Aboriginal people as barriers to access are reduced. However, the transfer of dispensing functions from pharmacies to AHSs has raised issues of ensuring QUM and appropriate pharmaceutical support.

As outlined above, data indicates that access barriers exist throughout Australia, and NACCHO's position was always that mechanisms to improve access should be available to all AHSs regardless of location. However, in over four years since the implementation of s.100, no progress has been made in securing better access for non-remote areas. This situation is not defensible and immediate change is needed.

¹² Hoy WE, Wang Z, Baker PR, Kelly AM. Secondary prevention of renal and cardiovascular disease: results of a renal and cardiovascular treatment program in an Australian aboriginal community. *J Am Soc Nephrol.* 2003 Jul;14(7 Suppl 2):S178-85

¹³ [You J, Hoy W, Zhao Y, Beaver C, Eagar K.](#) End-stage renal disease in the Northern Territory: current and future treatment costs. *Med J Aust.* 2002 May 20;176(10):461-5.

3. Should the next phase simply extend the existing s.100 system?

Commencing in 1999, s.100 in remote area Aboriginal health services provides over four years of experience which can be usefully considered in taking the next steps in improving Aboriginal access to PBS medications. A number of studies have been conducted which are relevant to this consideration, including the Hudson report¹⁴ and Quality Use of Medicines in Aboriginal Communities Project in 2001¹⁵, and the Loller report of 2003.¹⁶ These reports highlighted the importance of s.100 in improving access and the crucial role of pharmacy support services in maximising the benefits of the initiative. The review of s.100 currently being finalised by the Commonwealth Department of Health and Ageing is likely to reach similar findings.

Rather than simply extending existing arrangements, the second phase of improving medicines access for Aboriginal people presents an ideal opportunity to refine and enhance the existing s.100 model.

Clearly the key function of s.100 in providing access to PBS medications at no charge has revolutionised medicines access, and this feature must be of prime importance in improving non-remote access. However, both feedback on the current system and consultation with non-remote Aboriginal health services indicates two main areas where the current model of access could be improved.

First, access should be sufficiently flexible to accommodate AHSs' diverse needs and capacities. In particular, smaller AHSs in remote areas have struggled to meet the requirements of establishing, maintaining and operating on-site dispensaries, especially given the workforce, training and resourcing limitations widespread in the Aboriginal health care sector. A number of s.100 eligible sites, due to varying reasons such as capacity and legislative requirements, still require pharmacists to fully dispense medication for their clients. Under current s.100 arrangements, however, the choices are stark – either AHSs must run a bulk supply of medications on site, or the patient must revert to individual script dispensing with the attached co-payment. To provide a complete pharmaceutical care model for AHSs and address the inequity of PBS access, both the bulk supply, with pharmacy support services, together with the ability to access fully dispensed medications from the pharmacy should be made available. Any new model should allow for the flexibility to both supply medications directly on site and to have individual prescriptions dispensed by community pharmacists without a co-payment being charged in either case.

¹⁴ Hudson P. August 2001. *A summary of the prescribing and dispensing issues and needs in the remote health clinics of the Northern Territory*. General Practice Divisions Northern Territory and National Prescribing Service.

¹⁵ Emerson L, Bell K, Croucher K. 2001 *Quality Use of Medicines in Aboriginal Communities Project. Final Report 2001*. Canberra Pharmacy Guild of Australia.

¹⁶ Loller, H, 'Report from surveys conducted in Commonwealth funded Aboriginal Health Services and pharmacies supplying services under s.100 pharmacy allowance' May 2003

Secondly, the funding support to participating AHSs and community pharmacies must be significantly increased. When medicines are supplied under s.100, pharmacies may apply for a professional services allowance of between \$2,000 and \$4,500. This is a separate payment, which is designed to reimburse pharmacists for the costs of time and travel incurred in providing professional advice on the implementation of Section 100 and the promotion of quality use of medicines principles. This payment is not automatic and there is no mandatory requirement to provide (and claim for) this professional service. The recent Loller report found that there are less than 10 pharmacies accessing this allowance and identified recommendations to increase the uptake of this allowance.¹⁷

The current s.100 model moved the work of dispensary management and dispensing from pharmacies to AHSs but, other than the very minimal support allowance for participating pharmacies, funding was not supplied to support this process. Largely as a consequence of this, there have been concerns expressed by both AHS and pharmacies about some Quality Use of Medicines (QUM) issues. It is therefore important that implementation from this point include significant increases in funding for implementation and on-going support.

¹⁷ Loller, H. 2003, *Final report, Section 100 Support Project: Report from surveys conducted in Commonwealth funded Aboriginal Health Services and Pharmacies supplying services under Section 100 Pharmacy Allowance*. National Aboriginal Community Controlled Health Organisation & Pharmacy Guild of Australia, Canberra

4. Case study - Aboriginal Medical Service Co-operative, Redfern, NSW

Aboriginal Medical Service Redfern (AMS) runs a small dispensary, mainly stocking antibiotics, which are bought wholesale, and a small number of other medicines supplied as samples by pharmaceutical companies. Most medicines are provided to patients by normal PBS prescriptions, and the AMS has an account at the local pharmacy and meets the co-payment for around 10% to 15% of its patients who are in the most dire need. The AMS cannot afford to meet the co-payment for all patients in need, and is concerned that a great deal more of its patients need financial assistance with prescriptions and are not accessing medicines for this reason. A survey of their clients in 1997 showed only 10% to 15% were working, with the remainder subsisting on welfare payments. The AMS points out that rather than going in and out of jobs, most of their clients experience long-term joblessness and poverty, and with larger families and the high cost of living in Sydney, have great difficulties making ends meet. The AMS believes that medication reviews of their clients would probably find that the majority of people are not taking all or even any of their prescribed medicines, for cost reasons.

The AMS would be keen to dispense medicines on site with no co-payments, to ensure patients actually get their medicines and receive medication advice in familiar surroundings from trusted health care providers. The Medical Director who has worked in Aboriginal health for over 20 years stated that being able to run a free dispensary on site would be the single most productive initiative for Aboriginal health since the program was moved from ATSIC to the Commonwealth health department – there is little else that could make an impact of this dimension for so little cost in a comparatively short time frame. The AMS believes that pharmacist support in establishing and managing a Section 100 dispensary would also be helpful.

5. Proposed Model

5.1 Immediate implementation

The model proposed entails bulk supply through all participating AHSs, regardless of location. Legislative and other requirements mean access to a GP, at least on a part-time basis, is necessary in order to participate in the scheme. Bulk supply of medications is organised through a community pharmacy chosen by the AHS, with AHSs regularly lodging medication orders and being supplied these at no charge.

AHSs will also be able to write prescriptions that will be filled at a community pharmacy without a co-payment being charged. This could be achieved by the AHS quoting an allocated number, specific to the service, which would be used by the pharmacy to allow them to dispense medications and receive full payment from the HIC for supplying these medications.

Eligibility to participate in the scheme would be largely based on the s.100 criteria (see s100 eligibility criteria at [Attachment B](#)), with the exception of the removal of the current geographical limit to remote areas.

Funding

It is important that funding for the support of the bulk supply system is on a basis equivalent to the remuneration available to pharmacists for individual dispensing. The increased funding to community pharmacies would ensure the pharmacist is remunerated sufficiently to give the same time and care as he/she gives to all other dispensing and thus allow equitable access to pharmaceutical care. Given the increased funding quantum, it will be essential to establish efficient and robust mechanisms to ensure funding is properly used to support quality use of medicines in a way that meets the needs of pharmacists, AHSs and Aboriginal communities. Existing recommendations in regard to current s.100 arrangements, such as moves towards basing support to AHSs on a national pharmacy standard of practice developed through consultation with NACCHO and the PGA, are of increasing importance. On-going monitoring and refinement of these processes to build continuous improvement will be necessary.

The model should be implemented with sufficient support services for the AHS and community pharmacies, which will involve a significant injection of new monies to ensure infrastructure is in place, workforce requirements are assessed and additional training can be given to AHS staff, in a timely manner.

5.2 Future implementation

If the existing s.100 arrangements can be considered as Phase 1 in improving access to PBS medications, and the proposed model outlined above as Phase 2, there is clearly also a third phase required. Two main steps that would be necessary under Phase 3, would be to improve access to Aboriginal clients of prescribers not eligible under the proposed criteria, and, where appropriate, assisting AHSs to move towards managing on-site dispensing. Ideally, this process should be undertaken over the next three years.

Improving access to Aboriginal clients of prescribers not eligible under criteria

Prescribers not eligible under the proposed criteria would primarily include GPs in private practice. There is little good data on the level of access to private GPs by Aboriginal and Torres Strait Islander people, as efforts to identify Aboriginal or Torres Strait Islander status in the Medicare database are in their infancy.

Given the extreme economic and social disadvantage of Aboriginal and Torres Strait Islander people, and locational issues, key factors affecting the level of access to private GPs are the location of GPs (ie there are few in remote areas), the attitudes and approach of the GP/practice to Aboriginal and Torres Strait Islander people, and whether the practice bulk bills. Overall, while the average Australian sees a GP nearly five times per year,¹⁸ Aboriginal and Torres Strait Islander people average fewer than two GP consultations a year.¹⁹ Nevertheless, there are also many areas with no Aboriginal-specific primary health care services and so whether by default or otherwise, private general practitioners do play a significant role in Aboriginal and Torres Strait Islander primary care.

As the parties to this position paper are committed to working towards optimum access for all Aboriginal people regardless of location, access mediated by prescribers in mainstream general practice needs to be considered in the roll-out of PBS access improvements. The main issue to be considered in the inclusion of mainstream GPs is that of identification of Aboriginality. The accepted definition of Aboriginality has three necessary criteria: descent, recognition by the Aboriginal community and self-identification. The Aboriginal Community Controlled Health Services (ACCHS) sector deals with issues of such identification on a daily basis, whether prioritising access to scarce resources, such as dental services, or vouching for the identity of Aboriginal people in applying for Aboriginal-specific housing loans or scholarships. As an integral part of the community, ACCHSs are well positioned and respected in these matters. On the other hand, GPs in mainstream settings often struggle with issues of Aboriginal identification. Identification rates are often low in environments which Aboriginal people perceive as not offering cultural security, and, for example in hospitalisation data, vary depending on the where the question is asked, and by whom. Given the Government and the public's interest in ensuring any access program is properly targetted to Aboriginal peoples and Torres Strait Islanders, it is vital that identification processes are based in accepted processes in order to progress this next phase of implementation.

Assisting AHSs to move towards managing on-site dispensing

The proposed model is intended to provide flexibility for AHSs to determine their own capacity to manage on-site dispensing, and to provide the ability to generate prescriptions to be filled at the community pharmacy for those not in a position to do so for all dispensed medications. However, in Aboriginal communities, the ideal situation for holistic primary health care delivery remains the one-stop shop approach of on-site dispensing. To this end, it is also important to factor in better resourcing to the ACCHS sector to enable this approach to be a realistic option for local communities to consider. Needs based funding for primary health care services should therefore include recognition of the full costs of establishing and operating on-site dispensaries.

¹⁸ *The Government's Response to the Review of General Practice: General Practice – Foundation for the Future* (June 1998), p.5

¹⁹ Deeble et al, *Expenditures on Health Services for Aboriginal and Torres Strait Islander People*, May 1998, p.20 (Table 2.11)

6. Cost of model

Comparative to overall PBS expenditure, the proposed model would not entail significantly high costs. It should also be emphasised that the aim of the model is to improve Aboriginal health through removing access barriers to PBS medications – a citizenship right of all Australians. With current PBS expenditure on Aboriginal people approximately one third of expenditure on non-Aboriginal people, the model seeks no more than to achieve equity.

Estimations indicate that paying the dispensing fee of \$4.62 per item, rather than the lower handling fee of \$1.14, in areas currently eligible for s.100 would increase the total cost of the program by approximately \$1.8 million per year. An expansion of the program to non-remote areas would require expenditure of about \$41 million per year at prescribing rates based on current s.100 rates, or, if prescribing rates increase to the average Australian level, the cost would be approximately \$96 million.

In addition to these estimates of bringing PBS expenditure to a more equitable level, implementation costs of an extension of the program have been estimated at \$7 million over a three year period. This estimate includes start-up costs at the local level such as IT and dispensing room infrastructure and staff training, as well as funding for central support and promotion of the program.

Overall, ongoing expenditure required from the PBS is of the order of 2 - 3% of the total PBS cost, that is \$95 – 142.5 million. Interestingly, this is roughly equivalent to the percentage of Aboriginal people in the population, and thus would be the quantum of expenditure expected for basic equity.

The parties to this position paper are currently undertaking further economic analyses of these figures and may add further detail to them in the future where appropriate.

7. Next steps

The AMA, Guild and NACCHO now seek the endorsement of the Australian Pharmaceutical Advisory Council (APAC) for the position outlined in this paper. There are a range of issues to be further developed, especially in the area of implementation. The parties to this position paper are keen to work with stakeholders to progress these areas. However, the need for change is unquestionable and can no longer be delayed. APAC's role as the lead advisory body to the Health Minister on pharmaceutical issues, and its long-standing commitment to Aboriginal health through better access to and quality use of medications places it in an ideal position to sponsor this important initiative. As noted above, APAC has committed itself to facilitating better access to medicines for Aboriginal and Torres Strait Islander communities by next year, 2005. The approach put forward here provides a blueprint for achieving this objective.

The position is commended to the APAC Indigenous working party for consideration, with the intention being for an agreed position to be tabled for consideration at the full APAC meeting in Canberra, 17th – 18th June, 2004.

ATTACHMENT A

Excerpt from the National Health Act

NATIONAL HEALTH ACT 1953 - SECT 100

Special arrangements

(1)

The Minister may make such special arrangements as the Minister thinks fit for the purpose of providing that an adequate pharmaceutical service will be available to persons:

(a) who are living in isolated areas; or

(b) who are receiving medical [treatment](#) in such circumstances that the [pharmaceutical benefits](#) provided for by this Part cannot be conveniently or efficiently supplied in accordance with the general provisions of this Part.

(2)

The provisions of special arrangements made in pursuance of subsection (1) have effect notwithstanding any provisions of this Part inconsistent with those arrangements.

ATTACHMENT B

Current eligibility criteria for access to s.100

Eligibility criteria – supply of pharmaceutical benefits to remote area Aboriginal Health Services under section 100 of *National Health Act 1953*.

1. The Health Service must have a primary function of meeting the health care needs of Indigenous Australians.
2. The clinic or other health care facility operated by the AHS from which pharmaceuticals are supplied to patients must be in a remote zone as defined in the Rural, Remote and Metropolitan Areas Classification 1991 Census Edition.
3. The AHS must not be a party to an arrangement, such as a co-ordinated care trial, for which funds from the Pharmaceutical Benefits Scheme have already been provided.
4. The AHS must employ or be in a contractual relationship with health professionals who are suitably qualified under relevant State/Territory legislation to supply all medications covered by the Section 100 arrangements and undertake that all supply of benefit items will be under the direction of such qualified persons.
5. The clinic or other health care facility operated by the AHS from which pharmaceuticals are supplied must have storage facilities that will:
 - prevent access by unauthorised persons;
 - maintain the quality (e.g. chemical and biological stability and sterility) of the pharmaceutical; and
 - comply with any special conditions specified by the manufacturer of the pharmaceutical.