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Senator Rachel Siewert - Chair
Senate Standing Committee on Community Affairs References
Parliament House
Canberra ACT 2600

25th July 2011

Dear Senator Siewert
Reference: The effectiveness of special arrangements for supply of Pharmaceutical Benefits Scheme (PBS) medicines to remote area Aboriginal Health Services

I have pleasure in lodging the attached submission relating to the above Term of Reference.

I have been involved in pharmaceutical care in Aboriginal health for the past 14 years having started as the "Rural Pharmacist" at Katherine Hospital in 1997. I was then invited to join the policy area of Territory Health Service in Darwin to work on the introduction of the Section 100 arrangements for the Commonwealth to pay for the cost of Pharmaceutical Benefits Scheme items supplied to all remote Aboriginal Health Services whether they be operated by government or the community controlled sector. My previous experience in working for the Pharmacy Guild in Canberra and contact with bureaucrats in the Department of Health over the previous 20 years of my working life assisted in this role. This had also included 10 years with the pharmaceutical manufacturer Glaxo Australia for whom I was responsible for liaison with the Pharmaceutical Benefits Branch within the Department of Health.

Following my work in the Territory Health Service I was asked to assist the Tiwi Health Board to establish what still remains as the only pharmacy business owned and operated by a community controlled health organisation. This was successful. It is the knowledge I acquired in steering this operation that continues to inspire me to want to see similar operations in other communities. The fact the THB was forced to close due to inadequate government funding is another story. The pharmacy was a success but has not been replicated anywhere else despite legislation (in the NT) allowing Aboriginal Health Services to own a pharmacy business with Ministerial approval.

I have maintained a strong interest in the aspirations of this population sector and found it fascinating in terms of analysing how well the health system has adapted its service delivery to their needs. In the case of pharmaceutical care the outcome has not been good with a lot of work needing to be done to achieve pharmaceutical systems anywhere near the standards that exist in mainstream Australia. There is a huge gulf in the standard of pharmaceutical care and this is certainly not helping with efforts to "Close the Gap" through pharmaceutical interventions.

I want to congratulate your Committee and the Senate for making this reference possible. One of the huge problems for the 150,000 Aboriginal (and Torres Strait Islanders) who live in remote communities is that there are few people prepared to advocate on their behalf. They themselves do not know what a quality service means so are unable to appreciate what they are missing out on. Your Committee I hope will fill this void and conduct a thorough examination of all the factors that are having an influence on the quality of pharmaceutical care as a part of primary health care.

I trust my submission will add to the body of evidence to assist in your deliberations.

Yours sincerely

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SUBMISSION

Reference:

The effectiveness of special arrangements for the supply of Pharmaceutical Benefits Scheme (PBS) medicines to remote area Aboriginal Health Services

This submission will comment on the following Terms of Reference:

(a) whether these arrangements adequately address barriers experienced by Aboriginal and Torres Strait Islander people living in remote areas of Australia in accessing essential medicines through the PBS;

(b) the clinical outcomes achieved from the measure, in particular to improvements in patient understanding of, and adherence to, prescribed treatment as a result of the improved access to PBS medicines;

(c) the degree to which the 'quality use of medicines' has been achieved including the amount of contact with a pharmacist available to these patients compared to urban Australians;

(d) the degree to which state/territory legislation has been complied with in respect to the recording, labelling and monitoring of PBS medicines;

(e) the distribution of funding made available to the program across the Approved Pharmacy network compared to the Aboriginal Health Services obtaining the PBS medicines and dispensing them on to its patients;

(f) the extent to which Aboriginal Health Workers in remote communities have sufficient educational opportunities to take on the prescribing and dispensing responsibilities given to them by the PBS bulk supply arrangements;

(g) the degree to which recommendations from previous reviews have been implemented and any consultation which has occurred with the community controlled Aboriginal health sector about any changes to the program;

(h) access to PBS generally in remote communities; and

(i) any other related matters.

This submission will provide:

1. **Background to the introduction of the s100 arrangements for remote Aboriginal Health Services.**
2. **Models for pharmacy business practice in Aboriginal Health Services**
3. **Capacity building as a function of pharmaceutical care**

The program under review is a good example of how it is difficult to try and adapt a mainstream program to meet the needs of an Aboriginal population living in a totally different environment and obtaining healthcare by a method that is unique to their needs.

Pharmacy as a practice and profession has failed to fit in to the paradigm of remote Aboriginal health and must change direction if it is to contribute in a meaningful way to "Closing the Gap" in life expectancy between the Aboriginal population and non-Aboriginal population in Australia.

RECOMMENDATIONS

1. That the profession of pharmacy be included in all workforce planning that describes the professional makeup of the person power required to properly fulfil goals in primary health care treatment and management.
2. That Section 94 of the National Health Act be amended to allow Aboriginal Health Services to provide Pharmaceutical Benefit Scheme medicines to its clients.
3. The PBS put together a package which shows Aboriginal Health Services the advantages that will accrue to their clients from an "in house" pharmacy operation.
4. That the Department of Health and Ageing produce a guide for Aboriginal Health Services setting out how they should go about establishing an in house pharmacy service.
5. That the National Indigenous Health Equity Council be asked to examine the inequities that surround the supply of PBS Medicines to remote living Aboriginal persons.
6. That the PBS review it's funding under the Section 100 arrangements to remote Aboriginal Health Services and determine where it should be allocating funds to ensure there can be an equitable development of a method of supply to include quality use of medicine issues comparable to mainstream Australians.
7. That the S100 Support Allowance be disbanded and transferred to a fund from which guidance and mentoring can be provided to AHSs who want to initiate their own pharmacy business and have complete control over the pharmaceutical care program.

1. Background to the introduction of the s100 arrangements for remote Aboriginal Health Services.

The genesis of the s100 arrangements for the Pharmaceutical Benefits Scheme (PBS) to be delivered into remote Aboriginal communities came in 1997 when the Prime Minister, John Howard, visited remote health clinics in Cape York and Maningrida in the NT. There he found that in the treatment of trachoma the drug Azithromycin was not readily available and asked that a way be found to eliminate this disadvantage.

The result was an inquiry by the consulting firm Keys Young into barriers that were preventing Aboriginal people from accessing both the PBS and the Medical Benefits Scheme through the Health Insurance Commission.

The outcome for the PBS was special arrangements agreed by the Minister for Health to use Section 100 of the National Act to allow people living in remote communities to access the PBS.

The two peak bodies for pharmacy and Aboriginal health **-** the Pharmacy Guild and the National Aboriginal Community Controlled Health Organisation (NACCHO) were then asked by the Australian Pharmaceutical Advisory Council to formulate a plan for implementation.

The Rural, Remote and Metropolitan Area classification (RRMA) was used to define a remote area (Category 6 and 7) despite the Pharmacy Guild suggesting that a remote area be 25 Kms from the nearest Approved Pharmacy business. As this would have precluded larger towns in the NT which had both an Approved Pharmacy and a large ACCHO, the Minister agreed to use the aforementioned RRMA classification.

The entire "white pages" of the Yellow (covered) Schedule of Benefits was deemed to be available to remote Aboriginal community health services, regardless of any restriction, authority and special treatment that a person in mainstream would need to obtain such medicine.

This was a distinct advantage to clinicians as it meant for an Authority listed drug they did not have to obtain a special Approval Number and authorisation for prescribing the medicine in question.

The Pharmacy Guild was used to advise on the supply function and it (the Guild) saw this as a further way for its members to control and benefit from the supply of PBS process. This direction was taken up by the NT, WA and South Australia. In Queensland the supply is done through Queensland Health hospitals.
The outcome is a program for Aboriginal health services that is an extension of the mainstream PBS supply arrangements.
Any variations are hard to find as the proprietors of the retail pharmacies impose the standards and practices on to the AHSs which they would to another client of their retail shop. Competition has been stultified by a tendering arrangement where in the case of the NT and WA the State Health Department acts as the contractor for the Commonwealth and grants contracts to successful pharmacies to supply a selection of AHSs. This certainly orders the supply process. Through the "Support Allowance" there is an automatic income stream to meet the cost of twice yearly visits to the AHS. Strict work plans are supposed to be developed to allow the pharmacy to claim the cost of these visits.

The development of the Aboriginal Health Service pharmacy module has been done by persons with little or no experience of working in remote communities and with a lack of understanding of the complexities that engulf Aboriginal health. Every team player has a role and these roles have been established over time – the past 40 years. It is just not possible for a "new" health professional (pharmacist) to drop into the mix and be able to make an instant contribution.

A team effort is required and input from the others in the team should be sought to build a program. Everyone must be involved, including consumers, with some "buy in" to the process.

Pharmacists have to recognise that in the wider primary health care arena they are a very small part. Described at **ATTACHMENT A** is a story of a pharmacist who wanted to be involved in Aboriginal health only to be told there was no place. This basic fundamental of proving ones worth needs to be addressed before any significant steps can be taken. Pharmacists must be included in workforce planning for Aboriginal Primary health care. Without that recognition the next step of inclusion is made difficult by the policy planners.

2. Models for pharmacy business practice in Aboriginal Health Services
The views of this author in proposing a solution to the current woes which confront the remote AHS sector in pharmaceutical care is strongly influenced by the success obtained from the Pharmacy Project of the Tiwi Health Board (2001-2003).
Why is it that there are still few situations where good pharmaceutical care is being practised? The answer is simple.
There have been few pharmacists engaged in the process.
There have been few pharmacists prepared to advocate for the people living in these communities.
The people themselves have never experienced a quality service and thus do not know what they are missing out on.
The National Indigenous Health Equity Council within the CW Department of Health which would be hoped to take an interest in the subject was not interested saying it was outside their terms of reference. See **ATTACHMENT B. See Recommendation 5.**

The fact that when any Australian has a prescription dispensed in a mainstream Approved Pharmacy they have access to the advice of a pharmacist makes this a basic right of all citizens.

Unless of course the patient is a remote living Aboriginal person who obtains their Pharmaceutical Benefits through the Section 100 arrangements.
There is nothing fundamentally wrong with the s100 arrangement. It is a sound way for the Commonwealth to meet the cost of the medicines supplied as PBS items to remote AHSs.
The problem comes with the infrastructure upon which this is built and the totally inequitous way that the money being spent is being divided between manufacturer, retail pharmacy and Aboriginal Health Service.

[It should be noted that in Queensland the Health Department is maintaining the supply to Government health clinics so different circumstances apply to the situation in the NT, WA and South Australia.]

Pharmacists, when involved in primary health care, are trained to provide quality service functions that enhance the quality use of medicine for clients and streamline procedures for ordering and maintaining an inventory for a health service.
These are fundamental for achieving an efficient pharmaceutical care program which will include:

a. Educational programs for specific disease state client groups
b. Educational programs for clinicians including Aboriginal Health Workers
c. Good record systems for monitoring outgoing supplies and reports back to doctors on client medication adherence history.
d. Efficient inventory control to allow ease of ordering and stock replenishment.

This can be achieved by having a pharmacy business at an AHS Approved to supply PBS medicines to its clients and claiming the costs back through the Medicare Australia payment system.

The Tiwi Health Board established a pharmacy business on Bathurst Island as a part of the Health Board primary health care function and this provided a quality service.
See **ATTACHMENT C** – Reference from Bill Barclay – former CEO of Tiwi Health Board.

The "Approved Pharmacy" was established using the Rules of the Australian Community Pharmacy Authority pertaining to a "remote location". A Rule 114 says the pharmacy must be 10 Kms from the next nearest pharmacy. Almost ALL remote Aboriginal health Services meet this criteria.
For those which do not because they are positioned in a town centre where there is already an existing Approved Pharmacy there needs to be an amendment to Section 94 of the National Health Act to allow AHSs to be able to provide PBS to their clients.

The same approach could be used in other medium to large Aboriginal communities as shown in the map below:

All the communities listed above have a population of 1,000 or more. The PBS item volume would be likely to be in the order of 20,000 a year which in itself would generate an income of $70.000 a year. By the time additional fees for items such as Home Medication Reviews are added in this could well mean and income in excess of $100,000 to meet the cost of a pharmacist.

There are issues that would need to be worked through with the relevant peak bodies but so long as this is done against a background of a desire to improve the inequity between pharmaceutical care to remote Aboriginal people compared to mainstream there should be sufficient "goodwill" to want to see it happen.

There are two principles that need to be taken into account in considering this proposition:

1. The pharmaceutical service from an Aboriginal Health Service is an integral part of primary health care and should be established in the best possible way given the limitations of population size as a determinant for the degree of full time/part time nature.

2. The Pharmaceutical Benefits Scheme provides within its funding remuneration for buying in product; storing and maintaining an inventory; cost of dispensing; and, installing and maintaining a facility for electronic recording of dispensing information

It takes time to get to know a community, be accepted by the Aboriginal workers at the health centre and as a pharmacist be accepted as a part of the primary health care workforce. This requires positive contributions that can only be developed over time. A two day visit every six months is by no means enough and yet this is what the s100 "Support Allowance" provides for the supplying pharmacy.

3. Capacity building as a function of pharmaceutical care

If the 27 towns' on the map above all had a pharmacy operation attached to their primary health care facility it would mean the employment of some 100 plus persons working under the supervision of a Registered Pharmacist.

In addition to the direct employment is the chance to follow a new career path with study opportunities and involvement in a new function within the health care facility. Young children would see the medicines being dispensed, Dose Administration Aids packed and advice given on why medicines are essential to manage the symptoms of chronic disease.

Linda and Joachim pack Websterpaks under the guidance of Gerard Stevens, Managing Director of Webstercare. During the course of the Tiwi Pharmacy Project Webstercare offered considerable assistance with IT improvements

The Tiwi Health Board Pharmacy Project employed across the three health clinics on the two islands six persons and in the two years it was in operation one Tiwi person started at Charles Darwin University to study pharmacy while another was keen to become a pharmacy technician through the Charles Sturt University training program.

At a time when "close the gap" means not just life expectancy but also employment and education it is hard to see why an opportunity such as "pharmacy" is not progressed.

The workers developed computer skills, learnt about medicines, understood the importance of adherence and were able to speak to their people in their own language about any issues relating to their medications. They all became competent in their work and would have obtained a Pharmacy Technician Certificate without any problems.

The supply of PBS medicines from a distant Approved Pharmacy is not necessary when it can be provided directly to a local pharmacy business from a wholesaler or supplier. The margin made on cost and the handling fee can then become revenue towards the operating cost of the pharmacy business.

The range of product need only be what is required to supply the health clinic. That is unless other markets are decided to be followed such as hair care, skin treatments, dental care, vitamins and complementary medicines, first aid and the like.

Libby packs a Clamshell – an alternative to dosette boxes developed by Webstercare

Schania explains to senior Aboriginal Health Workers how the Websterpak looks compared to the dosette box

4. Addressing Terms of Reference.

(a) whether these arrangements adequately address barriers experienced by Aboriginal and Torres Strait Islander people living in remote areas of Australia in accessing essential medicines through the PBS;

There is no doubt access has been resolved and their should be no reason why any PBS medicine is not available to a remote living Aboriginal person.

However with the supply is the need for information. It is totally unreasonable to burden this to doctors, nurses and Aboriginal Health Workers when they have an already overladen workload. Pharmacists should be employed to undertake this task at the AHS level and the PBS pay an amount to cover the cost of dispensing as is done in mainstream. There is a deficiency of $3.68 and this should be paid to the AHSs to allow it to employ or contract a pharmacist to implement quality use of medicine measures.

(b) the clinical outcomes achieved from the measure, in particular to improvements in patient understanding of, and adherence to, prescribed treatment as a result of the improved access to PBS medicines;

There is no evidence available of what has been utilised through remote AHSs since the program began in 1999. This despite the suggestions of DoHA officers at the time that inter State and regional comparisons would be possible.

Data must be made available to allow proper evaluations to be done as proposed by Professor Wendy Hoy in her submissions to the Minister for Health and Minister for Indigenous Health.

(c) the degree to which the 'quality use of medicines' has been achieved including the amount of contact with a pharmacist available to these patients compared to urban Australians;

As outlined in the early parts of this submission the contact with pharmacists has been negligible. A two day visit every six months does not give any time to build rapport or understand local influences. The only way this can be really rectified is to have pharmacists on site actually running the business of a pharmacy using either a Section 90 or Section 94 Approval to dispense PBS.

The National Prescribing Service and its education program for pharmacists doing outreach work could also be improved upon with the choice of subject. At present the subject is said to be that identified by focus groups across Australia and may net bear and direct relevance to remote Aboriginal health and its priorities for action.

(d) the degree to which state/territory legislation has been complied with in respect to the recording, labelling and monitoring of PBS medicines;

The Tiwi Health Board project with the support of Webstercare developed the Mirrijini Dispense System for accurately recording out going supplies, labelling product and maintaining inventory control. From 2003 to 2005 the author was involved in trying to get other health services to see the merit of Mirrijini with the main feature being that State/Territory legislation would be met if they used the system. Unfortunately this meant nothing.

When no records had been kept in the past and no one was complaining why did the future have to be any different?

The search started in 2006 for a system that could be interfaced with the Patient Information Retrieval System. The search goes on, no recording is being done (in most instances) and hand written labels are still the norm.

(e) the distribution of funding made available to the program across the Approved Pharmacy network compared to the Aboriginal Health Services obtaining the PBS medicines and dispensing them on to its patients;

Immediate action is needed to meet the cost of dispensing at an AHS. It is despicable to learn that an Approved Pharmacy supplying a large Aboriginal health service in a regional centre is making a gross profit of $450,000 from just a supply function while the health service still has to pay from its general revenue $5 to have a prescription dispensed from the same Approved Pharmacy.

Pharmaceutical and other wholesalers could the job just as well in the supply function and for half the cost. A case for this is at **ATTACHMENT D**.

(f) the extent to which Aboriginal Health Workers in remote communities have sufficient educational opportunities to take on the prescribing and dispensing responsibilities given to them by the PBS bulk supply arrangements;
The Section 100 supply arrangements were only ever meant to be a means of the Commonwealth to meet to cost of the PBS. Whilst this should have included the cost of dispensing and thus the payment of a pharmacist's time it could not have stretched to include AHWs. If there is/was a pharmacist on site then this would be a part of their function.
The State /Territory Government always have and always should have the responsibility for AHWs education and training.
To try and claim this as a function of the s100 PBS Supply is stretching the bow.

(g) the degree to which recommendations from previous reviews have been implemented and any consultation which has occurred with the community controlled Aboriginal health sector about any changes to the program;
This author is unaware of any ongoing dialogue between the NACCHO and the DoHA with respect to recommendations from previous reviews.
There is one distinct recommendation from the Kelaher Review of 2004 which requires immediate attention and its delay can only be described as bureaucratic bungling and passing the buck to another Division or Agency. It is:

10. **Information about the performance of S100 would be improved if the following changes were made:**

10.1 **HIC should provide medicine utilisation data to ATSIHSs to enable them to keep track of their own performance.** Originally HIC was to provide clinics with data on their medicine utilisation, but this has not occurred to date.

10.2 **A system to assess the quantum of medicines that expires in ATSIHS should be considered to enable further evaluations.** This would help ATSIHSs judge the effectiveness of their inventory management. If such data could be collected in a consistent way it would also assist further evaluation by making it possible to show that increases in medicine utilisation were not due to waste.

10.3 **DoHA should update records of ATSIHS client numbers to ensure that any comparisons between centres are accurate.** In order to assess trends in medicine utilisation among different ATSIHSs the size of their client populations needs to be taken into account.

(h) access to PBS generally in remote communities;
The s100 PBS Supply arrangement for remote AHSs is an excellent mechanism for paying the for the cost of the medicines from the PBS.
The fact that the inventory of PBS medicines is owned by the PBS is a feature that many an Approved Pharmacy would like to see for its PBS inventory.
The claiming system is simple and the ordering system should also be simple.
This author urges the Senate Committee not to be side tracked by discussions on co-payment relief programs for non-remote Aboriginal patients such as the recently introduced "CTG" scheme as a part of QUMAX. These are urban programs and have a strong place in that environment.
If remote needs more strengthening in quality use of medicine there are ways of doing it that do not need the bureaucratic rules and guidelines as are laid down in the QUMAX program devised by NACCHO and the Pharmacy Guild.
The Aboriginal patient must come first and the more money that can be expended at the patient end of the supply chain the better.

TESTIMONIAL FROM A VICTORIAN PHARMACIST

24 May 2011

I thought I would just pass on my experience of attempting to provide medication review services to remote area health clinics. I saw an advertisement in the Age newspaper quite a while a go seeking expressions of interest from health professionals willing to work for short periods in remote areas health clinics on a fly in fly out basis.

I contacted the recruiters' rural workforce or some similar name and received a polite reply stating they were only looking for doctors, nurses, dentists, aboriginal health workers and allied health and did not have any positions for pharmacists. I would have thought that my training as an accredited consultant Pharmacist would have improved health outcomes for these patients in remote area clinics by providing them with education and information regarding their medications and the reasons that they should be taking them. I could have utilized my core skills in managing a dispensary to assist the local health workers in organizing and running their dispensary/depot efficiently as part of the clinic. I could have also ensured that medications were dispensed according to all the relevant legislation both State and PBS and provided counselling at the point of supply. I could have also taken on a training role to up skill the local health workers to conduct the dispensary and any DAA preparation according to prevailing legislation and PSA guidelines.

Pharmacists are just not considered part of the health workforce by the planners in the health bureaucracy in Canberra. What do we have to do to change this mindset which seems to be so entrenched that it is holding the whole profession hostage to the old paradigm of the retail strip "Chemist shop".
Pharmacists are part of the health workforce in the ADF, they are involved in logistics and supply of medications and other material to field hospitals, they may run dispensaries, clinics etc yet in the wider community Pharmacists are still seen primarily as shopkeepers.
Pharmacists are not seen to be adding value to the medication supply chain by the health bureaucracy and until we can show that our activities make a difference to heath outcomes the only objective of the Department of Health and Ageing will be to rein in PBS costs by cutting Pharmacist incomes as well as the number of Pharmacies to obtain efficiencies of scale and further drive down unit costs.
I have over 30years of experience working as Pharmacist in a variety of roles in both the community and in hospital. I now do not want to commit to long term stints working in remote areas however brief visits to share my expertise would be something that I am prepared to do. However no one in the Department of Health and Ageing seems to think that Pharmacists have any role in improving the health status of remote communities.
If we could improve medication compliance amongst the Aboriginal community then we would reduce medical and hospitalization costs downstream. Even in Melbourne medication compliance is major issue with urban Aborigines just go and ask any Aboriginal health service or clinic. Providing culturally appropriate healthcare is a major challenge and requires a great deal of co-operation between the local Aboriginal community and the health workers whether they be doctors, nurses, allied health or pharmacists.
People's beliefs regarding their own health, reasons for illness vary widely between cultures and this must be taken into account when tailoring health interventions.
ONE SIZE FITS ALL solutions do not work.

Personal communication between the writer and this author.

From: NIHEC@health.gov.au
Sent: Tuesday, April 27, 2010 4:29 PM
To: rollom@iinet.net.au
Cc: Terry.Oliver@health.gov.au ; nihec@health.gov.au
Subject: Fw: Inequity in PBS supply medicines to remote Aboriginal people [No Protective Marking] [SEC=UNCLASSIFIED]

Dear Mr Manning,

Thank you for your email regarding equity issues surrounding the supply of PBS medicines and I apologise for the delay in our response.

I have consulted with the Chair of the National Indigenous Health Equality Council (NIHEC), Professor Anderson, who advises that PBS medicines falls outside the scope of NIHEC's Terms of Reference and would therefore not be in a position to contribute to this work. NIHEC does not require any further briefing on this matter.

Please contact Kate Coffey, Director of NIHEC Secretariat on (02) 6289 7341, if you would like to discuss further.

Regards

National Indigenous Health Equality Council Secretariat
Email: NIHEC@health.gov.au

To Whom It May Concern

Rollo Manning has asked me to describe his abilities, and in particular his contribution to primary health care planning, and public health issues over the four years that I was acquainted with his work, including the time he was employed by the Tiwi Health Board, when I was its Chief Executive.

Rollo's efforts to improve pharmacy delivery systems to indigenous communities throughout the Northern Territory were well known amongst both within the Northern Territory Department of Health, and the innovative delivery organisations such as the Tiwi Health Board that were established by the Commonwealth from 1998 onwards. The latter were designed to overcome what could be described as criminally imbalanced delivery of health care to Aboriginal people, and pharmacy delivery constituted one of the major concerns.

In regard to public health, it had long been recognised that a conservative Northern Territory Government had stubbornly resisted the introduction of alternative Methadone based methods of dealing with heroin addiction in the face of overwhelming evidence as to its effectiveness. It is considered by many that unnecessary human suffering, and indeed death, was brought about by this policy, reinforced by reactionary elements within the department. Rollo Manning's resistance to this immoral and indefensible position brought about his removal from his policy advising role within the Department. His integrity was subsequently vindicated with a policy reversal following a change of Government.

It was the great good fortune of the Tiwi Health Board to be able to secure the services of Rollo Manning in order to improve its pharmaceutical services, and in the space of two years he brought about a total reform of the manner in which long established supply lines, pharmacy licensing (at least on Aboriginal communities) and dispensing took place. Huge steps were made in the face of profound resistance at the time from vested interests within the Pharmacy Guild and Government.

Rollo Manning's determination and vast knowledge of and contacts within the industry as a whole, have enabled him to prepare and implement plans with skill and great advantage to all the Aboriginal people with whom he has come in contact both in and outside of the Board. He has been responsible for innovative and effective pharmaceutical and health planning at all levels, and has the ability to contribute a great deal more to Aboriginal health generally.

It is imperative that Rollo Manning's ideas are fairly evaluated by those concerned with the implementation of new and more effective means of achieving equality of health outcomes throughout Australia.

Bill Barclay
27 July 2005

THE CASE FOR USING WHOLESALERS TO DO A SUPPLY JOB

A number of health services in the Northern Territory and Western Australia are obtaining their bulk supplies of PBS medicines from a local community pharmacy with no value add by the pharmacist. This is being done at a cost to the Commonwealth that far exceeds the cost were it to be supplied through a pharmaceutical wholesaler. The Senate Committee might consider that not only could this be done at a lesser cost but also in a more efficient manner considering that delivering medicine supplies in bulk is the expertise of wholesalers and not of community pharmacies.
The relevant mark up on cost is set out below sourced from the 5th Community Pharmacy Agreement:

Type of Payment	Basis of Payment	Value
Wholesale mark-up	**Mark-up on ex-manufacturer's price**	
	Up to and including $930.06	7.52%
	Over $930.06	$69.94
Pharmacy Mark-up	**Mark-up on Approved Price to Pharmacist**	
	Up to and including $30.00	15.00%
	Between $30.01 and $45.00	$4.50
	Between $45.01 and $180.00	10.00%
	Between $180.01 and $450.00	$18.00
	Between $450.01 and $1750.00	4.00%
	Over $1750.00	$70.00

To demonstrate the savings using pharmaceutical wholesalers to make the supply instead of community pharmacies the following example is given:
In 2009/10 there were 1,370,840 PBS items supplied for a total cost of $38,844,976.
This is an average cost of $28.33
Let's say a PBS medicine manufacturer's price to wholesaler is $20.00
Add a 7.52% margin for the wholesaler when supplying to a pharmacy = $1.50.
Price to pharmacy is thus $21.50.
The pharmacy then adds 15% when supplying to the PBS = $3.22
The price to the PBS is now $24.72.
In supplying on in bulk to an Aboriginal health service the pharmacy also adds a $2.74 "handling fee".
The price to the PBS Section 100 arrangement scheme is now $27.46.
Thus had the goods been supplied from a wholesaler in the first instance the price to the PBS would have been $5.96 less than the supply from a pharmacy. Across the 1,370,840 items this would have released $8,170,206 to be used on additional value add activities to encourage adherence such as employing pharmacists.
Added to this benefit is the fact that wholesalers have sophisticated systems for ensuring proper inventory control, placing of orders and the tracking of orders at any time. In some cases this has revolutionised the supply process, giving healthcare providers direct access to a warehouse of over 15 000 products via their PC. The software is free of charge, easy to use and allows the healthcare professional to control the entire ordering process.
Such an arrangement avoids the frustration of back orders, short supply and allows maximum and minimum stock levels to be established based on past supplies.
The cost of freight is not taken into account in the above calculation. Prior to the introduction of the s100 arrangements over 10 years ago the health services had to meet the cost of freight but then in the negotiation with the Pharmacy Guild it was offered for the supplying pharmacy to meet the freight costs.