The Pharmacy
Guild of Australia

Ref: POLGOV vos

17 August 2011

Ms Toni Matulick
Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Ms Matulick

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

I refer to your letter of 16 August 2011 regarding comments the Committee has received from Mr Rollo Manning that may be interpreted as containing an adverse reflection upon the Pharmacy Guild of Australia (the Guild).

The Guild appreciates the opportunity to respond to the comments made by Mr Rollo Manning. Whilst the Guild accepts that recollections of history of the Section 100 Remote Aboriginal Health Services Program (S100 RAHSP), made many years after the events, may be affected by recall bias we believe it is important that factual errors are corrected wherever possible using available documentary evidence.

We believe the comments are not an accurate representation of what occurred during the development of the S100 RAHSP. The comments could be interpreted to mean that the Guild was instrumental in creating the program from the very beginning simply to suit its members, which reflects poorly on both the Guild and its membership.

In an effort to clarify the history of the S100 RAHSP we refer the Committee to the "*Evaluation of PBS Medicine Supply Arrangements for Remote Area Aboriginal Health Services Under S100 of the National Health Act*" prepared by Margaret Kelaher *et al.* In part 3 of this evaluation Kelaher provides a detailed history of the development of the S100 RAHSP and the Guild would draw the Committee's particular attention to page 48 and 49 of the evaluation which states:

> "In 1995 the NACCHO (and KAMSC) chairman, Dr Puggy Hunter, was invited to sit on the Australian Pharmaceutical Advisory Council (APAC). In September 1995 a NACCHO paper was tabled at APAC proposing urgent reform of medicine supply arrangements for Aboriginal communities based on a modified S100 supply arrangement still operating in the Kimberley. APAC was an unusual peak advisory group in that it was one of the only forums with senior-level representatives from all major professions, industry, government and community. Dr Hunter worked closely with the APAC chairman, Professor Lloyd Sansom, to mobilise this network to develop the current S100 supply arrangements for remote ATSIHSs. Professor Sansom recalls that:
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> *He would tell me things and I would say 'It can't be like that – this is Australia'. He took us on a 10-day trip so we could see for ourselves. This reaffirmed the importance of community-controlled health services in providing services*

National Secretariat
Level 2, 15 National Circuit, Barton, ACT 2600 Australia
PO Box 7036, Canberra Business Centre, ACT 2610 Australia
Telephone: + 61 2 6270 1888 · Facsimile: + 61 2 6270 1800
Email: guild.nat@guild.org.au · Internet: www.guild.org.au

but we also saw a need to involve the Pharmacy Guild. We were worried that if medicine were given with no dispensary involvement then there would be no control.'"

"At a subsequent Darwin meeting of the Isolated and Remote Medicines subcommittee of APAC in early 1998, access and administrative problems were strongly illustrated by site visits to the Bagot Health Service and Danila Dilba Aboriginal Medical Service and this was a key turning point. The Committee recognised that:

Aboriginal health services functioned best as a one-stop shop where use of medicine was integrated into total client support and health education and where ATSIHWs could be readily involved in education and supply. (Dr Murray KAMSC)

The development of the new arrangements moved forward once support was gained from the Guild, based on bulk supply arrangements being brokered through community pharmacies. This supported the viability of community pharmacies in remote areas and meant that ATSIHSs could deal with a single supplier and order smaller quantities rather than large 'shelf-pack'. It also allowed the emergence of local partnerships between ATSIHSs and pharmacists.

The S100 arrangements appear to be an elegant solution to a difficult problem. Ms Kathy Bell, who was involved both in the development of S100 at DoHA and its implementation by NACCHO suggests that the successful introduction of S100 was really the result of a convergence of factors. First of all, the desire to change the supply of medicine came from the grass roots; it was identified by NACCHO and there was a strong sense of ownership of the issue. This support was very important because policies often fail due to insufficient consultation and a lack of ownership. APAC and DoHA listened to what NACCHO was saying and sought to bring together a group of people to address the problem and develop political support for reform. There were committed people from a number of areas – NACCHO, APAC, DoHA, and the Guild – all working together.

Whilst the Guild does not deny that it was asked to provide expert opinion on proposed models during the development of the Program and provided representation at various meetings, to suggest that the Guild saw this Program as a further way for its members to control and benefit from the supply of PBS process is inaccurate and inappropriate. On the contrary, pharmacists involved in the Program have demonstrated a commitment to health outcomes. The most recent evaluation in 2010 by Australian Health Care Associates (AHA) indicated that they were "impressed by the level of commitment of community pharmacists working with Aboriginal Health Services (AHS), state/territory or community controlled organisations, which provide primary health care services to Aboriginal and/or Torres Strait Islander people. These pharmacists are driven by a desire to improve health outcomes for people residing in remote Australia".

Ms Shelley Forester, a community pharmacist and member of the Guild recalls that the initial S100 scheme proposed by the Health Insurance Commission (HIC) which was developed by APAC and NACCHO required AHS's to order directly from a pharmaceutical wholesaler and then claim back the expense from the HIC themselves. This would have placed the administrative burden onto already overstretched AHS staff, meant that the AHS bore the risk of carrying the cost of medicines if they didn't manage claiming appropriately or the HIC rejected their claims for any reason, and most importantly denied the patients of the AHS any pharmaceutical care – there would have been no pharmacist involved in the pharmaceutical supply chain whatsoever.

We would also like to point out that it is not strictly correct to state that "in Queensland supply is done through Queensland Health" as the Guild, during its survey of pharmacies, identified at least 5 pharmacies in Queensland providing services to AHS's.

I trust that this clarifies the historical details relating to the development of the S100 RASHP and I thank you for the opportunity to provide a response. If you have any further questions please don't hesitate to contact Mr Vincent O'Sullivan on 02 6270 1888 or via email: Vincent.osullivan@guild.org.au

Yours sincerely

Wendy Phillips
Executive Director