CHAPTER 2

THE IMPLEMENTATION OF THE PHARMACEUTICAL RESTRUCTURING MEASURES – ADMINISTRATIVE AND LEGISLATIVE FRAMEWORK

Introduction

2.1 The administration of the pharmaceutical restructuring measures was significantly affected by the framework within which it operated. The Committee found that delay in putting in place all the necessary legislative instruments was a problem which exacerbated those arising from the administration of the measures. Some of the components of the restructuring measures as designed were flawed and brought about a number of unforeseen and unintended consequences which diminished the impact of the rationalisation program, and, in some instances, even ran counter to its objectives.

The time frame

2.2 The administrative and legislative arrangements which were to enable the implementation of the pharmaceutical restructuring measures spanned a period of six months, from the time of the Minister's first announcement that the Government and the Pharmacy Guild of Australia had come to an agreement about restructuring the pharmacy retail industry, to the gazettal of Ministerial Determination No. PB1 on 23 January 1991.

2.3 The following chronological table highlights the protracted steps through which the restructuring arrangements moved before all the measures proposed could be implemented. For convenience, in this chapter and the following ones, this period will be referred to as the transition period.

1 July 1981

(Departmental procedures in respect of approval of pharmaceutical chemists become effective – still operative at 8 August 1990).

24 July 1990

The Minister for Aged, Family and Health Services announces that an Agreement has been reached with the Pharmacy Guild of Australia for the restructuring of the pharmacy retail industry.

8 August 1990

The Minister announces that restrictions in the granting of new approvals to dispense Pharmaceutical Benefits Scheme (PBS) prescriptions will take effect immediately.

9 August 1990

The Health Insurance Commission (HIC) begins applying new procedures in respect of applications for approval received from that date.

20 September 1990

Community Services and Health Legislation Amendment Bill 1990 introduced in the House of Representatives. The Bill provided for the establishment and functions of the Pharmacy Restructuring Authority (PRA) and for guidelines to be determined by the Minister before the Authority can discharge its functions.

10 October 1990

Social Welfare Legislation (Pharmaceutical Benefits) Amendment Bill 1990 introduced in the Senate; contained a provision enabling the Pharmaceutical Benefits Remuneration Tribunal (PBRT) to make a determination giving effect to an agreement between the Government and the Pharmacy Guild or another pharmacists' organisation (new section 98BAA).

18 October 1990

Above Bill passed.

30 October 1990

Social Welfare Legislation (Pharmaceutical Benefits) Amendment Act 1990 is given Royal Assent.

23 November 1990

Agreement between the Commonwealth of Australia and the Pharmacy Guild of Australia for the restructuring of the retail pharmacy industry. Subsequently declared null and void on the technicality that section 98BAA of the *National Health Act* requires an Agreement with a Minister of State, not the Commonwealth.

6 December 1990

Signature of an Agreement between the Minister for Aged, Family and Health Services and the Pharmacy Guild – Date of effect subject to a determination by the Pharmaceutical Benefits Remuneration Tribunal (PBRT).

18 December 1990

Community Services and Health Legislation Amendment Act 1990 is given Royal Assent – The PRA is legally established. The HIC ceases being the decision-maker in respect of approvals to supply pharmaceutical benefits although the Authority is

not fully empowered to operate – the legislation provides that the PRA must comply with a Ministerial determination yet to be signed and gazetted.

20 December 1990

PBRT determination giving effect to the Agreement between the Government and the Pharmacy Guild as from 1 January 1991.

9 January 1991

Determination No PB1 of 1991 required under section 99L of the *National Health Act* signed by the Minister.

23 January 1991

Gazettal of Ministerial Determination No PB1 of 1991. The PRA is now fully empowered to begin operations.

8 February 1991

The PRA begins processing applications.

Consequences of the time frame

1. Ministerial media releases

2.4 In view of the six months' lapse of time between the Minister's media releases and the beginning of operations by the PRA, and of the complete absence of supporting documentation on the restructuring, the timing of the Minister's statements was questioned by the Committee.

2.5 Evidence submitted to the Committee revealed that the restructuring operations were begun without adequate guidelines or instructions. DHH&CS justified the commencement of restrictions despite 'the absence of detailed operational guidelines' by the following statement:

> . . . The Government and the Guild were negotiating a settlement package which involved remuneration and restructuring. The remuneration aspect of that was to save the taxpayers $14 million per month, and priority was given to putting that agreement in place.[1]

2.6 The Department has stressed frequently in evidence that the anticipated economies to be achieved on the remuneration front justified the absence of guidelines on the restructuring at the time of the Minister's media release. In a communication to the Committee, it stated:

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1. *Transcript of Evidence* (DHH&CS), 27 November 1991, p. 994.

> The Department does not believe in the circumstances that the decision to make an early announcement . . . was inappropriate. For each month's delay in implementing the agreement would have resulted in a cost of $14 million of foregone savings.[2]

2.7 The Committee noted, however, that the latest savings projections provided by the Department show a loss of $3.4 million for the relevant part of the 1990-91 financial year[3] as opposed to an estimated net savings for the same period of $19.7 million[4] as estimated at 30 June 1991. The Committee presumes that in the long term, some savings will be made through the restructuring.

2.8 Announcing the restructuring of the pharmacy retail industry was an inevitable sequel of announcing progress on the remuneration question which, over the previous year, had been at the centre of the confrontation between the Government and the Pharmacy Guild.

2.9 In evidence submitted to the Committee, a representative of the Pharmacy Guild acknowledged that:

> a lot of the problems stemmed from the period when the Minister announced the freezing of approval numbers . . . At that time there were no fixed procedures for anybody to follow.[5]

2. The Government/Guild Agreement

2.10 The Agreement sealed the deal between the Government and the Pharmacy Guild and contained details of all arrangements which, both parties claimed, would 'produce a more efficient community pharmacy structure'.[6] As long as the Agreement was not finalised, the HIC had the minimum of information on the requirements to determine 'prior commitment'. Yet, this was the period when applicants claiming to have already made arrangements in the expectations that approvals would be granted[7] were the most numerous.

2.11 Delay in the finalisation of the Agreement left a vacuum for the operations of the HIC. Much uncertainty resulted from decisions made with no back up of any kind. There was a lack of coherence in the interpretation of the Minister's statement and in the manner in which the restrictions were imposed. This caused much

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2. DHH&CS to the Committee, 5 February 1992.

3. DHH&CS to the Committee 23 April 1992.

4. *Transcript of Evidence* (DHH&CS), 23 August 1991, p. 66

5. *Transcript of Evidence* (Pharmacy Guild of Australia), 15 November 1991, p. 809.

6. Agreement, 'General objectives', para. 2.1.

7. As per the Minister's media release of 8 August 1990.

confusion among pharmacists and created a lot of ill-feeling. A number of submissions presented to the Committee relate directly to developments which occurred during the transition period. As these are closely linked to the administration of the program, they are discussed in more detail in the following chapter.

2.12 This initial delay was compounded by the fact that the date of effect of the Agreement was subject to the making of a determination by the Pharmaceutical Benefits Remuneration Tribunal as expressed in paragraph 1.6 of the Agreement itself. Finally, the application of the guidelines contained in the Agreement could not take place until 23 January 1991 when the Pharmacy Restructuring Authority was fully empowered to carry out its mandate under the *National Health Act 1953*, as discussed below.

3. The *National Health Act 1953* as amended by the *Community Services and Health Legislation Amendment Act 1990*

2.13 For the purposes of this inquiry, the *Community Services and Health Legislation Amendment Act 1990*, which came into force on 18 December 1990, provided for amendments to section 90 of the *National Health Act 1953* by removing the discretionary powers of the Departmental Secretary to grant or reject an application for approval to dispense pharmaceutical benefits, inserting new subsections to enable the Pharmacy Restructuring Authority (PRA) to perform its role in the granting of approvals under this section of the Act, and adding a new Division 4B to Part VII to establish the PRA and detail its functions.[8] The new provisions only partially transferred functions in respect of approvals to the PRA but removed any previous powers of the HIC to deal with applications for approval. Thus from 18 December 1990 until 23 January 1991, all applications were in limbo.[9]

2.14 Delay in the passage of the necessary legislation for the establishment and functions of the PRA further contributed to the extended transition period. As indicated at paragraph 2.3 above, the amending Act was introduced in the House of Representatives on 20 September 1990. Had the 1990 Autumn Sittings legislative program not been severely shortened on account of the federal election, with a consequent heavy program for the Budget Sittings, it is possible that the Act would have been passed and received Royal Assent at an earlier date.

2.15 But the PRA could not function until the Minister had made a Determination under section 99L of the Act. Given that the relevant provisions of the Act received Royal Assent on 18 December 1990, this provision caused further delay. The end of year is not a particularly propitious period to put in place all the instruments required by a complex set of statutory arrangements.

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8. Relevant legislation is at Appendix 5.

9. *Transcript of Evidence* (HIC), 27 November 1991, p. 958.

4. Ministerial Determination No PB1 of 1991 under section 99L of the *National Health Act 1953*

2.16 'The last piece in the legal jigsaw'[10] was put in place with the gazettal of Ministerial Determination No PB1 of 1991 on 23 January 1991. Between the amendment to the *National Health Act 1953* which brought in new arrangements for the granting of approvals on 18 December 1990 and this gazettal, no applications could be processed. The net result of this was an 'overwhelming' number of applications waiting consideration when the PRA began operations on 8 February 1991. As these could not all be dealt with at once, there were some delays in finalising them. This caused some concern to people who had applied for an Essential Pharmacy Allowance (EPA), as in some instances there was a gap of several months between lodging of an application and receipt of first allowance.

Recommendation

The Committee RECOMMENDS:

1. That all legislation and subordinate legislation relating to the Pharmaceutical Benefits Scheme and the pharmaceutical restructuring measures be consolidated in one Act and associated Regulations.

Ministerial media releases

2.17 The Minister's first media release was primarily concerned with making a public statement on improved relations between the Government and the Pharmacy Guild. It did however make a broad statement on the forthcoming restructuring of the retail pharmacy industry without giving more details about a commencement date or procedures. It was more precise on the remuneration component of the restructuring, referring to the preparation of submissions to the Pharmaceutical Benefits Remuneration Tribunal.[11]

2.18 By contrast, the second Media Release entitled 'Pharmacy restructuring – Restrictions on approvals' required immediate administrative action in respect of the rationalisation of the pharmacy industry: restrictions in the granting of approvals to dispense pharmaceutical benefits were to be imposed as from the following day, 9 August 1990.[12]

2.19 The Minister's announcement established three categories for the future handling of applications for new approvals:

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10. Professor D. Whalan, Report to the Committee, 10 December 1991.

11. Minister for Aged, Family and Health Services, Media Release 24 July 1990. See Appendix 4, *op. cit.*

12. Minister for Aged, Family and Health Services, Media Release, 8 August 1990. See Appendix 4, *op. cit.*

- approvals in respect of applications already lodged [but not finalised] at 9 August were to 'be dealt with in accordance with the **rules which currently apply**'. In other words, there was to be no change of policy or procedures regarding these applications.

- approvals in respect of applications lodged on 9 August 1990 and thereafter were to be handled in one of two ways:

  (i) either applicants had 'entered into commitments with the expectations that approvals would be issued'. In these instances the applications were to be dealt with '**on a case by case basis**'; or

  (ii) applicants [had not entered into a 'prior commitment']. In respect of these, **approvals to dispense PBS prescriptions were to be 'issued in accordance with criteria presently being established'**.

2.20 Several points arise from the Minister's media release. In the absence of accompanying legislation or guidelines of any kind and in view of the immediate departure from the *status quo* regarding granting of approvals that the statement implied, this media release represented a policy change.[13] The implications deriving from this situation in the domain of public administration have been examined with the assistance of expert legal advice.

2.21 At the time of the Minister's announcement, the Health Insurance Commission (HIC) was responsible for all the operational aspects of the Pharmaceutical Benefits Scheme (PBS) including the issuing of approvals to dispense PBS prescriptions while DHH&CS had responsibility for policy and budgeting. It followed that it was incumbent on the Commission to take all steps necessary for the proper implementation of the Minister's directions of 8 August 1990. It will be shown later in this chapter that the position and role of the HIC in the administration of the PBS was not straightforward. The splitting of functions between two agencies hindered rather than facilitated the introduction of new arrangements in relation to the PBS.

2.22 Other aspects of the media release have also come under scrutiny:

- It was the only information available to the HIC to guide it in carrying out the new measures for the granting of approvals;

- It failed to define 'commitments entered into'; and

- it advocated a 'case by case' approach to decision-making which led to inconsistencies in the administration of the program.

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13. *Transcript of Evidence* (HIC), 27 November 1991, pp. 960, 970.

2.23 Evidence provided to the Committee made it quite clear that the Minister's media release of 8 August 1990 was the only 'guideline' available to officers of the Health Insurance Commission for granting new approvals.[14] The departure from existing policies and procedures which the Minister's statement implies therefore raised the question of its appropriateness as a tool of government. The ancillary question was whether the HIC was in any way empowered to participate in the restructuring.

2.24 These questions were examined in the context of the existing legislative and procedural arrangements which governed the granting of approvals for pharmacists to dispense pharmaceutical benefits, because:

> The existing state of the law and practice had a crucial bearing on the decisions to be made on applications right up until the time that the restructuring changes became effective.[15]

– existing legislation on the approval of pharmacists at 8 August 1990

The National Health Act 1953

2.25 The approval of pharmacists to dispense PBS prescriptions is covered by section 90 of the *National Health Act 1953*. For the purposes of this inquiry, the more significant points of this section provide for the granting of approvals at the discretion of the Secretary or his delegate (subsection 90(1)) and for the subordination of granting such an approval to State or Territory requirements (subsection 90(4)).[16]

2.26 Other provisions of the Act are also relevant to our inquiry. Section 6 of the Act provide for the delegation of the Secretary's powers by an instrument of delegation. This had in fact occurred on 12 July 1989 in preparation for the transfer of PBS operations to the HIC on 17 July 1989. This instrument of delegation was revoked and replaced by a new one signed by the Secretary on 26 June 1990.

2.27 A decision to reject an application made under section 90 of the Act was subject to a review under subsection 105AB(7) of the Act. This power of review had rarely, if ever, been invoked as granting of approvals had always been such a mundane affair. However, with the introduction of restrictions, this provision acquired new significance. It will be seen that failure to amend the provision when changes were made to section 90 placed a number of pharmacists whose application was rejected by the PRA in a non-reviewable position.[17]

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14. *ibid.*

15. Professor D. Whalan, Report to the Committee, 10 December 1991, p. 2.

16. The full text of the section is at Appendix 5.

17. See below, paragraphs 2.90-2.91.

2.28 The legal opinion provided to the Committee on the validity of the Minister's media release of 8 August 1990 was that '[it] was not legally binding on anyone'.[18] However in the light of existing law and practice as examined above, the Committee was advised that:

> . . . Section 90 of the *National Health Act 1953* gave the Secretary a discretion to grant or reject an application made by a pharmacist for approval. As the Secretary's powers had been delegated to the Health Insurance Commission by amendments to the Health Insurance Commission Regulations in 1989, this meant that the Commission had an apparently wide discretion to grant or reject an application.[19]

2.29 In response to the comment on the legal limitations of the Minister's Media Release provided by Professor D. Whalan who was appointed as the Committee's legal adviser, the Department of Health, Housing and Community Services drew the Committee's attention to the provision of section 138 of the *National Health Act 1953*. Under this section, the exercise of a power by the Secretary under the Act is subject to the directions (if any) of the Minister. The Department concludes:

> it is therefore possible to regard the Minister's announcement of 8 August 1990 as being, in effect, a direction to his delegates on the exercise of their section 90 approval power.[20]

2.30 The Committee has sought legal advice on this point and has been informed that, unless the Department can provide additional documentation in support of this suggestion, it is unlikely that the Minister's media release became a formal statutory process.[21]

Recommendation

The Committee RECOMMENDS:

2. That the Government discontinue the practice of relying on press releases to introduce changes in public administration.

State requirements

2.31 Until the criteria for the rationalisation of the retail pharmacy industry were finalised and the PRA could exercise its functions under the *National Health Act 1953* as amended, subsection 90(4) contained the only restrictions applicable to the

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18. Professor D. Whalan, *op. cit.*, p. 4. A summary of Professor Whalan's advice to the Committee is at Appendix 7.

19. *ibid.*, p. 1.

20. DHH&CS to the Committee, 5 February 1992.

21. Professor D. Whalan, Report to the Committee, 3 March 1992.

granting of an approval under the Act. Compliance with State or Territory requirements prior to approval to dispense pharmaceutical benefits implied that:

(i) the pharmacist be registered with the State or Territory Pharmacy Board or Council; and

(ii) the premises at or from which the pharmacist intended operating be approved by the State Board or Council and also be registered.

2.32 These formalities had wider implications. The pharmacist could only be registered if he/she had completed relevant studies, and strict criteria applied for the approval of premises.

Procedure manual

2.33 The only guideline available in respect of this restriction to officers engaged in processing applications for approval was provided by a Departmental Procedure Manual dating from 1 July 1981. Subparagraph 17.2.1.2 reads:

> Reasonable care should be exercised to ensure that the intended pharmacy conforms with the requirements of and is approved by State and local authorities before approval action is taken.[22]

2.34 Once this requirement had been satisfied, the granting of an approval was a straightforward procedure. As the Health Insurance Commission submitted:

> Approval has been automatic upon the Secretary or his delegate being satisfied that the applicant had the relevant State approval to conduct a pharmacy at the premises referred to in the application.[23]

2.35 In the eyes of pharmacists, the procedures to obtain approval to dispense pharmaceutical benefits was perceived as quite straightforward. The Committee heard in evidence:

> From my understanding, before all this came in [the restrictions], getting an approval number was not more than ringing up and saying "Hey, I am opening a new pharmacy down the street. Can you give me an approval number, please".[24]

2.36 This informal approach to the granting of approvals to dispense PBS prescriptions made it all the more difficult for HIC officers to implement suddenly a more exacting procedure and for pharmacists to realise that things had radically

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22. Department of Health: Procedure manual – Pharmaceutical Benefits – Processing of claims.

23. *Transcript of Evidence* (HIC), 23 August 1991, pp. 330-31.

24. *Transcript of Evidence* (Prowse), 2 October 1991, p. 577.

changed in the procedures for granting approvals. The ramifications of this aspect of the restructuring are examined at paragraphs 3.19 to 3.26 below.

– granting of approvals in line with the Minister's announcement

2.37 The only restructuring operations which the HIC could carry out during the transition period were those relating to granting of approvals as this facet of the PBS was already covered by existing legislation. Furthermore, of the Minister's three categories of applications for approval, the HIC could practically only deal with two: applications already lodged at 8 August 1990 which were to be treated as all applications had been to date; and applications lodged after 8 August 1990 where applicants had already began making arrangements expecting to receive an automatic approval once State approval had been given. There was nothing the HIC could do about new applications for which criteria were not yet developed.

– applications lodged before 9 August 1990

2.38 These applications were to be dealt with under existing rules as contained in section 90 of the *National Health Act 1953* and in the Procedure Manual (1981). Since there was no change in the criteria applying to these applications, there should not have been any problem. However, the removal of the Secretary's discretion in section 90 of the *National Health Act 1953* and the establishment of the PRA at the same time meant that any applications lodged before 9 August 1990 but not finalised at 18 December 1990 could no longer be dealt with by the HIC. The PRA's incomplete powers to perform its functions under the Act until 23 January 1983 and the omission in Ministerial Determination No. PB1 of 1991 of the provision applicable to these applications meant that, in fact, these applications remained in limbo until 28 May 1991 when a new Ministerial Determination came into force. The confusion which arose in respect of these applications following the gazettal of PB1 are examined in the following chapter.

– applications lodged after 8 August 1990 claiming prior commitment

2.39 The concept of 'prior commitment' soon became, and remains, a controversial aspect of the restructuring arrangements, being the initial reason for this inquiry.[25] Although evidence of prior commitment represented the first hurdle at federal level in the granting of approvals and was therefore a major development, no attention was paid to its meaning. On the contrary, the Committee heard that an absence of definitions of some of the essential concepts of the restructuring arrangements was not seen as a problem. In the event, this approach to the program's details caused a multitude of problems.

2.40 The HIC had not been a party to the discussions between the Government and the Pharmacy Guild regarding the restructuring and developed its own definition of 'prior commitment'. The unqualified term 'commitment' of the

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25. A summary of this case is at Appendix 3.

Minister's release was first confined to 'an assumption of commitment'[26] but soon acquired more precise definition. By 9 September 1990, the HIC was requiring applicants to prove that financial and legal obligations were entered into prior to 9 August 1990. The Committee was told in evidence:

> There was nothing in the Minister's press release to indicate the extent of what a commitment should be, so the documentation was viewed purely on the prima facie case of what the documentation should be.[27]

2.41 The permutations for what constituted 'commitment' were numerous and evidence was given to the Committee on a wide range of situations which have arisen from the application of a new criterion, the first major change in what used to be an unrestricted procedure. The possibility that there could be 'people who feel aggrieved because they perceive that their applications have been judged by different criteria and procedures'[28] was of concern to the Committee. These situations are examined below at paragraphs 3.71 to 3.75.

2.42 The 'case by case' approach advocated by the Minister's statement only exacerbated the effects of the HIC having to make decisions on the basis of changing criteria. Information provided to the Committee has highlighted the complications which in some instances have emerged from the handling of these applications by the HIC. The Committee is however of the opinion that poor administrative procedures also played a large part in the complications which arose from the Minister's ill-defined policy statement and these are examined in the following chapter.

Applications lodged after 9 August 1990 to be decided on criteria 'being established'

2.43 The main problem resulting from the Minister's statement in respect of this category of applications has proved to be the failure on the part of the Health Insurance Commission to appreciate the difference between this type of application and those examined in the previous paragraphs. Correspondence with pharmacists and memos to State Offices from HIC Central Office reveal limited understanding of the different components/stages of the pharmaceutical restructuring measures and demonstrate careless use of terminology. The following sentence was included in a pro forma response to pharmacists who applied for approval between 9 August and 18 December 1990:

> The Minister for Aged, Family and Health Services announced on 8 August 1990 that temporary restrictions would be placed on the issuing of new approvals to dispense PBS prescriptions. Pharmacists who have entered into commitments with the expectations that

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26. *Transcript of Evidence* (HIC), 2 October 1991, p. 636.

27. *Transcript of Evidence* (HIC), 27 November 1991, p. 971.

28. *Transcript of Evidence* (DHH&CS), 23 August 1991, p. 114.

approvals would be issued will have their expectations deal[t] with on a case by case basis.[29]

2.44 It could be argued that failure on the part of the Minister or the Department to issue further instructions regarding the introduction of new procedures and properly identify the different categories of restrictions which were to apply is the source of the problems affecting the implementation of the restructuring measures. The HIC has told the Committee that it had not been involved in the negotiations prior to the media release. Its position as the administrator of the first restructuring measures was not a sound one.

2.45 It could conversely be advanced that an agency with statutory powers should be in a position to devise a coherent administrative strategy and take the necessary steps to implement a national program efficiently.

Guild/Government Agreement

2.46 The criteria announced by the Minister on 8 August 1990 as 'presently being established' were contained in Part II of the Agreement between the Minister and the Pharmacy Guild. Part I of the Agreement, referred to as the Section 98BAA [of the *National Health Act 1953*] Agreement, is concerned exclusively with the new remuneration arrangements for pharmacists dispensing PBS prescriptions. This Part of the Agreement is the one on which the attention of both the Government and the Guild focused, to the detriment of the second Part of the Agreement which consists mainly of the arrangements put in place for the rationalisation of the pharmacy retail industry.

2.47 The arrangements consisted of:

(i) closure and amalgamation payments for those pharmacists prepared to relinquish their approval number to dispense PBS prescriptions;

(ii) payment of an additional allowance to pharmacists operating in remote or isolated areas to ensure continued community access to PBS dispensing; and

(iii) conditions to be met for the granting of a new approval to dispense PBS drugs.

2.48 Evidence tendered in the course of this inquiry has shown that in many respects, the criteria established 'were grossly deficient'.[30] A number of details have come under criticism from a wide cross section of interested parties. Even the architects of the Agreement acknowledged that there was a lack of precision in the Agreement and that the criteria adopted would need reviewing.

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29. Health Insurance Commission to pharmacists, August-November 1990, HIC Correspondence.

30. *Transcript of Evidence* (Mrs Mihulka) 6 September 1991, p. 364.

> Those who negotiated the Agreement recognised that there were certain problems and that there would be changes to criteria from time to time . . . When the agreement was formulated, those who negotiated it believed that there would be a mechanism that would be put in place in the early stages.[31]

2.49 Such statements indicate that notwithstanding the fact that the arrangements were incomplete, the restructuring went ahead regardless of the consequences. Yet neither the Government nor the Guild expressed any reservations about the implications of launching a national program which had not been adequately designed. In the light of the long feud between Government and Guild over remuneration and the arrangements finally agreed to in order to obtain a resolution of the impasse, it is perhaps understandable that remuneration was the top priority. The Committee was told time and again about the anticipated savings to be made from an early introduction of the new remuneration arrangements. The restructuring, on the other hand, was to be solely financed by the Government for the first eighteen months.

2.50 Failure of the architects of the Agreement to pay proper attention to the finer details of the rationalisation arrangements is evidenced in:

- the loose terminology of certain provisions;
- the lack of a clear definition of some of the key concepts of the restructuring; and
- the inflexibility of some of the criteria set.

2.51 The effects of these factors have ranged from confusion about the parameters and even the aims of the restructuring to inconsistencies in the application of the criteria set and in some cases to results contrary to the aims of the rationalisation.

– loose terminology

'Guidelines'

2.52 The Committee noted the multiple uses of this term in documentation relating to the restructuring.

2.53 The 'criteria being presently established' represented a first category of guidelines, directions which were to facilitate the implementation of restructuring measures. Thus, when on 30 November 1990, the HIC advised State Office staff that new 'guidelines' were now operational, the reference was to an extract from the Agreement as first signed on 23 November 1990. This was done notwithstanding the fact that this document was subsequently declared null and void, was not signed again until 6 December 1990 and could not become effective until the

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31. *Transcript of Evidence* (Pharmacy Guild of Australia) 23 August 1991, p. 259.

Pharmaceutical Benefits Remuneration Tribunal made a determination in respect of Part I of the Agreement.

2.54 Nevertheless, the Agreement gave the first full scale indication of the scope of the restructuring arrangements – some of which had been under way since August 1990. Its eventual release as 'guidelines' should have been problem-free, had it not contained references to yet another type of guidelines.

2.55 Paragraphs 6.1 relating to the closure and amalgamation payments, 7.3 dealing with the Essential Pharmacy Allowance (EPA) and 8.5 on the granting of approvals all contain provisions which are subject to 'guidelines issued under the [National Health] Act'. Thus a new set of guidelines appears in the documentation: those 'determined in writing' by the Minister under section 99L of the Act 'subject to which the Authority is to make recommendations under subsection 99K(1)'.

2.56 Although the two sets of 'guidelines', with one or two critical exceptions, covered the same arrangements with respect to EPA, closure/amalgamation payments and guidelines on the granting of approvals, there is a vast difference between them: one only having a legal status by virtue of the link between Part I ('the section 98BAA [of the *National Health Act 1953* Agreement') and Part II as expressed in paragraph 1.6; and the other being a mandatory requirement under delegated legislation.

2.57 While the Agreement may have been justly perceived as 'guidelines' by those who, for four months, had nothing to back up their understanding of the restructuring, the use of the term with two different parameters in the Agreement itself had nothing to do with the HIC, but with those who drafted the document.

2.58 The possibility that the multiple usages of the term may have added to the overall confusion which characterised the progress of the restructuring cannot be dismissed. The references in paragraphs 6.1, 7.3 and 8.5 of the Agreement did not facilitate the implementation of the pharmaceutical restructuring measures.[32]

'Freeze period'/Freezing of approval numbers

2.59 Paragraph 3.1 of Part II of the Agreement provides details relevant to funding of closure and amalgamation packages. Within that context, there is a reference to the 'freeze period' as defined in Part I of the Agreement – that is a period of 18 months from the coming into effect of the agreement during which the dispensing fee will be frozen.

2.60 Throughout the inquiry the Committee has heard references to the 'freezing of approval numbers' announced by the Minister on 8 August 1990. Both the Guild[33], and the HIC[34], as well as various witnesses have used this expression.

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32. See paragraph 3.25 and footnote 21 above on Guidelines. See also Appendix 7.

33. *Transcript of Evidence* (Pharmacy Guild), 15 November 1991, p. 809.

The use of the expression is inaccurate: the only applications which could not be processed were those relating to approvals to dispense PBS prescriptions from new premises, lodged after 9 August 1990 and not claiming 'prior commitment'. All other applications could be dealt with as they were received. There was therefore no freeze. In view of the fact that the term is precisely defined in Part I of the Agreement as it applies to the dispensing fee, this is another illustration of the confusion which obtained in relation to the restructuring arrangements.

– lack of definitions

Closure and amalgamation payments

2.61 Financial incentives in the form of lump sum payments were to encourage pharmacists to choose either to close or amalgamate their existing pharmacies. This aspect of the restructuring has badly backfired. The offer of sums ranging from $45,000 to $80,000 without any proper parameters was almost bound to become open to abuse.

2.62 Under paragraphs 6.2 and 6.3 of the Agreement, the longer the number of continuous years an approved pharmacist has dispensed PBS prescriptions from particular premises, the higher the lump sum payment s/he can receive in respect of the closing pharmacy. The Committee heard of a couple of instances where a pharmacist owning two or more pharmacies in close proximity of each other applied for a closure package in respect of the oldest pharmacy – often the most viable – and received a large payment. The pharmacist then proceeded to move the other not so viable pharmacy into the premises of the now 'closed' pharmacy. The Committee has been concerned by this development and raised the issue during the Inquiry.

2.63 When questioned on the loophole, the Department expressed the opinion that the aim of the restructuring had been met in that there had been a reduction in the number of pharmacies. The Committee was further told that there had also been a benefit to the taxpayer.[35] The Guild at first expressed the view that this was a regrettable loophole which should not be[36], but later changed its mind and considered that there would be so few pharmacists in a position to exploit the loophole that it was not a cause for concern. In addition, the Guild expressed the opinion that it was 'perfectly legitimate for any person to maximise his income if the guidelines allow that to happen'.[37]

2.64 The Committee was told of a pharmacist who retained a non-viable second pharmacy and incurred serious losses while waiting for the Authority to begin operations. As soon as it did, he applied for a closure package in respect of his older

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34. *Transcript of Evidence* (HIC), 2 October 1991, p. 585.

35. *Transcript of Evidence* (DHH&CS), 23 August 1991, pp. 110, 111.

36. *Transcript of Evidence* (Pharmacy Guild of Australia), 23 August 1991, p. 254.

37. *Transcript of Evidence* (Pharmacy Guild of Australia), 15 November 1991, pp. 798-99.

pharmacy and immediately relocated the newer pharmacy to the site of the old one. As the witness concluded: 'a door never closed'.[38] It needs to be stressed that the use of the term 'closure' is in most cases a misnomer: what it really means is relinquishing approval to dispense PBS prescriptions.[39]

Recommendation

The Committee RECOMMENDS:

3. That the Government take necessary steps to ensure the elimination of loopholes in the restructuring measures identified by the Committee.

2.65 This development is an aberration of the intent of the restructuring, although the Department has argued that whatever the means, the end of reducing the number of pharmacies has been achieved and furthermore it brings about benefits to the taxpayers:

> The taxpayers benefit from the restructuring substantially through the reduction in remuneration that was part and parcel of the restructuring agreement with the Guild.[40]

2.66 Nevertheless, the Committee is concerned at the manner in which this practice represents additional expense on the taxpayer. Furthermore, this development has created an atmosphere of antagonism among groups of local pharmacists and has not enhanced the integrity of the restructuring in the eyes of a number of pharmacists.

'Prior Commitment'

2.67 The absence of definitions has also been noticeable in respect of the guidelines relating to the granting of an approval pursuant to section 90 of the *National Health Act 1953* – paragraphs 8.1 to 8.6 of the Agreement. The issue of 'prior commitment' has already been mentioned. The Committee was given ample evidence of the repercussions which flowed from the lack of guidelines. In particular, the Committee noted the wide range of documentation which was accepted or required as evidence of prior commitment. In one particular instance, a handshake over a verbal agreement was considered adequate[41], in another a signed lease had to be presented.[42] The failure to authenticate some of the documentation submitted

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38. *Transcript of Evidence*, (Mrs Mihulka), 6 September 1991, pp. 366-67. On this point, see also pp. 110, 117, 254, 257.

39. *Transcript of Evidence* (PRA), 15 November 1991, p. 868.

40. *Transcript of Evidence*, (DHH&CS) 23 August 1991, p. 111.

41. See Appendix 3.

42. *ibid.*

in support of applications has led to a number of difficulties in the early days of the restructuring.

2.68 Given that the introduction of this restriction was to be immediate, the lack of definition or parameters was all the more significant. In the event, the HIC devised its own definition as it went along.

2.69 In its submission to the Committee, the HIC detailed its requirements in respect of 'prior commitment' as consisting of:

- documentation of deposits made for lease/rent of premises;
- documentation of funds paid for a lease or rent of premises;
- tender documentation to show construction of premises to house a pharmacy;
- statutory declarations from vendor, solicitor, or accountant confirming commitment to establish a pharmacy;
- copies of bank statements evidencing funds paid;
- a signed legal document committing a pharmacist to acquire premises for a pharmacy.[43]

2.70 This submission was prepared on 23 July 1991, long after the HIC had ceased being the decision-maker in respect of the granting of new approvals. Evidence presented to the Committee in the course of the inquiry and correspondence sighted on HIC files do not reveal such clear parameters to the 'financial and legal' requirements during the transition period when clarity was necessary.

2.71 The development of definitions as the program progresses has had a number of implications for pharmacists. Thus a pharmacist claiming prior commitment on 9 August 1991 was given immediate approval[44] on the assumption of prior commitment. On the other hand, a pharmacist whose application was considered by the PRA had to meet much stricter criteria as a result of the definition adopted by the Authority at its meeting of 10 May 1991. The operative base of each authority was quite different: the HIC could almost do as it pleased with these applications; the PRA was bound by a Ministerial determination.

2.72 Financial commitment was defined to mean:

> a commitment as a duty or responsibility on the part of an applicant pharmacist . . .

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43. *Transcript of Evidence* (HIC), 23 August 1991, p. 333.

44. *Transcript of Evidence* (HIC) 2 October 1991, p. 636.

that the commitment is ongoing and binding

> . . . it is of a binding and irrevocable nature in the form of an agreement which means that the consequences of failing to honour the commitment [leads to] the existence of a substantial penalty.[45]

2.73 The Committee has been concerned at the ensuing injustices which may have occurred when applications have been judged by different criteria.[46] This arose partly from the fact that the guidelines were enshrined in delegated legislation and the PRA had a mandatory obligation to abide by these, partly from the fact that more definite parameters to the requirements for 'prior commitment' had finally been formulated. Between 'an assumed prior commitment' on 9 August 1990 and the hard and fast requirement of providing evidence and affidavits, there was the whole gamut of requirements which operated while the HIC dealt primarily with these types of application. The situation was aggravated by the fact that the largest number of these applications were received during the transition period when guidelines were vague or non-existent and applications were dealt with on 'a case by case' basis. This was yet another source of confusion and frustration among pharmacists and has been the source of several submissions to the Committee. The Committee also noted the confusion which arose in some instances as a result of the incorrect advice provided to pharmacists. These issues are covered in more detail in the following chapter.

'Unmet public need'

2.74 The wording of paragraph 8.4 of the Agreement seems to indicate that 'demonstrated community need' was to be the overriding consideration in dealing with an application for approval. Yet no definition was attached to the use of the term in the Agreement. The Committee was told that:

> There has been no guidance given to the PRA beyond that [the reference in the agreement], and there was no guidance coming out of discussions between the Guild and the Government about how you would go about defining unmet community need.[47]

2.75 In March 1991, the PRA issued a Newsletter in which it informed pharmacists that the onus was on any applicant to demonstrate 'unmet public need'. The only guideline provided was that any application claiming 'unmet public need' should 'show the demographics of the area and also indicate other health services available

45. *Transcript of Evidence* (PRA), 15 November 1991, p. 841.

46. *Transcript of Evidence* (DHH&CS), 23 August 1991, pp. 113-14.

47. *Transcript of Evidence* (DHH&CS), 23 August 1991, p. 94.

to the population'.[48] The PRA itself had no parameters within which it could assess whether an applicant had in fact demonstrated unmet public need.[49]

2.76 The Committee was told that up to one hundred applications for Essential Pharmacy Allowance were rejected because of the lack of a clear definition of unmet need.[50] By August 1991, the PRA had not yet granted one new approval to dispense PBS medications on this criterion.[51] Besides having difficulties defining what equated to 'community need' the PRA was of the view that it had no authority under the legislation to set criteria.[52]

2.77 The disregard of this criterion has produced outcomes in conflict with the stated aims of the restructuring as far as continued access to the PBS is concerned. Rejection of applications for EPA without due regard to public need has led to a large number of closures in remote areas which were not intended.

2.78 The Committee has now been told that the:

> [the definite unmet need] would override any other limitations and, in association with that, the PRA would not be able to recommend the approval of a closure or an amalgamation grant to a pharmacist where there were no competitors within 10 kilometres . . . This will mean that all pharmacies with no competitor within 10 kilometres will be automatically eligible for EPA.[53]

2.79 This may represent an improvement in the operations of the restructuring measures and assist in overcoming earlier deleterious consequences of flawed measures in the Agreement. The Committee has been advised that seven applications for approvals have now been granted on the 'unmet public need' criterion, two of which have resulted from the new distance factor mentioned in the paragraph above.

– inflexibility

Essential Pharmacy Allowance (EPA)

2.80 Paragraphs 7.1 to 7.8 of the Agreement cover arrangements which were applied to the granting of an EPA, some of which have been found to be so flawed

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48. Transcript of Evidence, (PRA), 15 November 1991, p. 835.

49. *Transcript of Evidence*, (DHH&CS, PRA), 23 August 1991, pp. 94-99, 115-6, 198-9, 258.

50. *Transcript of Evidence*, (Ms Mihulka), 6 September 1991, p. 374.

51. *Transcript of Evidence*, (PRA), 23 August 1991, p. 301.

52. *ibid*,. pp. 301-02.

53. *Transcript of Evidence* (DHH&CS), 27 November 1991, p. 988.

that remedial action has already been taken by the Government as described at Chapter 4, Part 2. The aim of the allowance is to retain pharmacy community services in areas where, if these were not available, the community would be severely disadvantaged. The allowance is based on an additional payment per prescription up to 1,000 prescriptions in a month.

2.81 To qualify for the EPA, a pharmacist had to fulfil three requirements:

- be at least 10 kms from the nearest pharmacy;
- dispense less than 1,250 prescriptions a month on an average; and
- be open to the public for at least 20 hours a week.

2.82 All these criteria have been considered by witnesses appearing before the Committee as unsound.

- What constituted the 'nearest pharmacy' in a remote area could well and truly be far more than 10 kms away;
- The volume of prescriptions is subject to variations which are beyond the control of pharmacists, i.e. a change of medical practitioner may mean change in prescribing habits; and
- A pharmacist could very well manipulate the opening hours to become ineligible for an EPA and therefore eligible for a closure payment.

2.83 The Committee was also concerned by the proviso that there were to be annual reviews of the criteria for EPA, as a result of which the Agreement stipulated that pharmacists in receipt of EPA would have to reapply annually for the allowance. In the opinion of the Committee, these pharmacies were particularly vulnerable.[54] Annual reviews of the criteria meant that eligibility for EPA would change from year to year and could lead to some pharmacists losing eligibility under different criteria. This issue has now been resolved in the manner described at paragraph 4.15 of this report.

2.84 The arrangements as formulated have in fact created a category of pharmacists who were themselves placed in a disadvantageous position vis-a-vis their city brethren. Their exclusion from closure/amalgamation payouts did not exclude them from the arrangements contained in other parts of the Agreement whereby pharmacists were to begin contributing to the cost of the restructuring by accepting a reduction in the dispensing fee. The Essential and Isolated Pharmacy Association claimed that the flow of prescriptions was often determined by factors beyond the control of the pharmacist, i.e. a change of doctor and ensuing prescribing

54. *Transcript of Evidence,* (DHH&CS), 23 August 1991, pp. 106-109.

habits. The vulnerability of pharmacists in isolated areas on account of the proposed annual review of criteria was seen as unsatisfactory.[55]

2.85 Since the restructuring has been under way, a number of developments have taken place to highlight other shortcomings in the application of the guidelines established to achieve a rationalisation of the pharmacy retail industry. Thus, the Committee has been told of the immediate and long term effects of closure of a pharmacy in low socio-economic areas where 'a disadvantaged group' is exposed to further disadvantages: the credit which may have been formerly available is no longer possible, nor is the counselling; lack of private transport accentuates the difficulty of getting to a more distant pharmacy; shortage of cash also makes the process of getting prescriptions filled more difficult; friendly neighbours cannot help with transport to the nearest pharmacy; disabled people are often not able to deal with public transport.[56] Yet the guidelines preclude a new approval being granted within five kilometres of this site for five years.

2.86 Similar situations have arisen in one-pharmacy towns where resident pharmacists have applied for and been given closure packages, thus leaving the area without a pharmacist for the next five years. The Committee has received two submissions from concerned residents of small country towns at either end of the country.[57] In each instance the pharmacy servicing the town and surrounding areas has closed, leaving the population without ready access to PBS facilities. As one of the submissions pointed out:

> If people have to go out of the region to obtain prescriptions, there is a real danger that they will stop using the local doctor also and eventually this valuable service would be lost to rural people.[58]

2.87 The Committee was told that in the case of Bowraville, arrangements have been made for the prescriptions to be faxed to the nearest town and an elderly retired chemist brings the prescriptions to the Bowraville Medical Centre where they are collected by the patients. There is much added inconvenience for the local population which the Committee notes does not fit in well with the stated aim of the restructuring.[59]

2.88 The plight of one-pharmacy towns under the restructuring arrangements of the Agreement are partially linked to the handling of applications for Essential Pharmacy Allowance. In evidence to the Committee, the Isolated and Essential

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55. *Transcript of Evidence*, 23 August 1991, pp. 106, 109, 262-3, 213-4, 195-6, 122.

56. *Transcript of Evidence* (Dr Kable), 6 September 1991, p. 391ff.

57. Koorda Shire Council, (Submission No. 1) and Bowraville Senior Citizens Club (Submission No. 25).

58. Koorda Shire Council, *op. cit.*

59. Bowraville Senior Citizens Club, *op.cit.*

Pharmacy Association highlighted the inequity faced by pharmacies in rural areas. The reference to the number of scripts dispensed – less than 1,200 per month on average – placed the eligibility for EPA at the mercy of factors such as a change in medical practitioner and ensuing changes in prescribing habits.[60] The adoption of the 'unmet community need' as the overriding criterion, as mentioned at paragraph 2.78 above, should put an end to this regrettable consequence of the restructuring as implemented in its first year of operations.

The National Health Act 1953

2.89 Decisions of the Secretary or his delegate under subsection 90(1) of the *National Health Act 1953* were subject to review by the Administrative Appeals Tribunal (AAT) under subsection 105AB(7). When the Act was amended to give the PRA responsibility for granting or rejecting an application for approval to dispense PBS drugs, the Secretary's powers under subsection 90(1) 'were circumscribed by subsection 90(3)' transferring the decision-making to the PRA. As no accompanying amendment was made to subsection 105AB(7), the AAT determined that its powers to review a decision were equally circumscribed.[61]

2.90 The absence of adequate appeal mechanisms for pharmacists directly affected by an adverse decision under the new restructuring arrangements was a major – though unintended – defect of the amended legislation. The legislation has now been amended. The Committee noted, however, that the matter was not suspected until an aggrieved pharmacist took his case to the Tribunal only to be told that the Tribunal was not empowered to deal with his case. In the meantime, the pharmacist in question has sustained not only unnecessary expenses but also much inconvenience.

Ministerial Determination No. PB1 of 1991

2.91 The restructuring had been in progress for more than six months, and the new remuneration arrangements effective as from 1 January 1991, when Ministerial Determination No. PB1 of 1991 was signed by the Minister. This document was to provide the guidelines which the PRA had a mandatory obligation to follow under subsection 99K(2) of the Act. The omission from these guidelines of a provision in respect of applications lodged prior to 9 August 1990 meant that these could not be processed by the PRA. Nor could the HIC continue to deal with these since it was no longer empowered to grant approvals. In the event, this led to misinterpretation of the legislation by the HIC which is examined at paragraph 3.31 below.

2.92 In respect of eligibility for an EPA, the determination specifies that a closure or amalgamation payment shall not be recommended in respect of premises which would qualify for an EPA. This is far more restrictive that the provision in the

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60. *Transcript of Evidence* (Isolated and Essential Pharmacy Association), 23 August 1991, pp. 192-194.

61. Administrative Appeals Tribunal, Decision No NS1/290, 21 June 1991.

Agreement which limits the exclusion to the acceptance of an EPA. According to a witness, a number of pharmacists in remote areas have been denied the availability of a closure payment on the ground that they met the criteria for an EPA.[62]

2.93 The gazettal of Ministerial Determination No. PB1 of 1991 officially brought to an end the transition period of the restructuring and opened the way for the PRA to take over all the restructuring operations. To accomplish its mandate, it was given a range of legislation which, while being an improvement on what the HIC had to operate the first stage of the restructuring, was still open to criticism and led to new problems. While the Committee acknowledges that the negotiating parties may not have had any inkling of the time frame which would be required to lay the foundations of the restructuring, it is nevertheless concerned at the laxity with which the framework was assembled and the numerous side-effects which have been revealed so far.

2.94 A number of the initial weaknesses have now been redressed and the current situation is examined in chapter four. To a certain extent this remedial action pre-empts some of the recommendations of the Committee, but may have been clarified by the inquiry. The Minister's announcement of 24 July 1990 must be seen in the context of the negotiations then in progress regarding the adoption of a new remuneration formula about to be submitted to the Pharmaceutical Benefits Remuneration Tribunal for its ratification. In all likelihood, the negotiations must have been intense given the impasse at which relations had come a few months previously. Yet the repeated claim that progress on the remuneration question necessitated the beginning of an ill-prepared restructuring must raise questions. The Committee has been told that:

> There was common knowledge that the discussion was taking place between the Government and the Guild. There was concern about pharmacists putting [in] applications on a speculative basis ahead of any announcement being made. So the view of both the Government and the Guild was that there had to be an early announcement.[63]

2.95 It would appear that the thrust of the media release of 8 August 1990 was to contain the speculative possibilities referred above until the restructuring could go fully ahead. The lack of proper attention to all facets of the restructuring ensured that in the initial stages there was considerable chaos and confusion about the program. Inevitably these flowed to the latter stages when the Pharmacy Restructuring Authority took over.

The key players

2.96 Evidence gathered during the proceedings of this inquiry indicates that the involvement of first two and then three government agencies in the restructuring

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62. *Transcript of Evidence* (Ms Mihulka), 6 September 1991, p. 373.

63. *Transcript of Evidence* (DHH&CS), 27 November 1991, p. 996.

operations has played a part in the manner in which the program has progressed to date. A brief examination of each major party to the restructuring will throw more light on the course of the program and the background against which restructuring evolved.

– The Department of Health, Housing and Community Services (DHH&CS)

2.97 When the restructuring measures were first applied on 9 August 1990, the then Department of Community Services and Health (now DHH&CS) was still responsible for two PBS functions: policy and budgeting. It has been shown in this chapter the extent to which the importance attached to the cost saving aspect of the restructuring diverted attention from the finer points of the rationalisation component.

2.98 Both the HIC and the PRA perceived the policy function of the Department as hindering their freedom of action or as explaining their not being responsible for the lack of clear guidelines. The Committee was told more than once that 'It is the responsibility of the Department to look at policy issues'.[64] On the other hand the Department expressed the view that:

> It was not the Department's responsibility to provide directions to the Health Insurance Commission. Clearly the Department was involved in establishing the agreement with the Pharmacy Guild. That flowed through to the restructuring arrangements, putting restrictions on new approvals as an interim measure. The delegation that the Commission was exercising was the Secretary's delegation in relation to approvals . . . The person who has a delegation given him cannot have that delegation fettered.[65]

2.99 This lack of consensus between all parties about their respective roles did not help the course of the restructuring, since it precluded some firm definition being given to the initial stages of the restructuring and created a situation leading to an uneven and unequal treatment of the measures adopted. Given that the Department was involved in the negotiations with the Guild, as stated above, it would have seemed reasonable to provide the HIC with some modicum of advice. There is no indication whatsoever that the HIC was at any time privy to some of the ideas about the restructuring being considered. On the contrary, witnesses have told the Committee that the first inkling they had of the details of the restructuring came with the release of an extract of the Agreement on 30 November.

2.100 The Committee has further been told that 'there is no functional relationship between the Commission and the Department' but that there are on-going

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64. *Transcript of Evidence* (HIC), 27 November 1991, p. 949.

65. *Transcript of Evidence* (DHH&CS), 27 November 1991, p. 993.

discussions.[66] The ramifications of this situation for the on-going course of the restructuring belong to the administration arena and are highlighted at paragraphs 3.90 to 3.94 below.

– The Health Insurance Commission (HIC)

2.101 Although the HIC is a statutory body established under the *Health Insurance Commission Act 1973*, as far as the PBS is concerned its relationship with DHH&CS has up to a point fettered its independence. Thus the PBS functions were split between the two agencies upon the transfer of PBS operations to the HIC. In fact what occurred was that all departmental personnel engaged in PBS operations were transferred to the HIC which took over the physical features such as buildings, but the data base remained with the Department for several months while the HIC was establishing a new system.[67] The transfer was not finalised until June 1990, less than two months prior to the commencement of restructuring operations.

2.102 Evidence before the Committee indicates that the Pharmaceutical Benefits Branch of the HIC was not able to make the adjustments required during the restructuring transition period. This is examined in the following chapter.

– The Pharmacy Restructuring Authority (PRA)

2.103 With regard to its position in the restructuring arena, the PRA has its own set of problems. Although a statutory body, it reports to the Minister and the Department provides secretariat support. But it is also dependent on the assistance of the HIC for a number of processes relating to granting or rejecting applications. This leads to rather convoluted procedures. In addition, its operations are sanctioned by Ministerial Determinations and within the context of the restructuring and the criticisms which have been made, it has very little flexibility in dealing with the applications before it. In the event, its powers 'to redress defects' are limited[68].

Recommendation

The Committee RECOMMENDS:

4. That the development of any national program be supported by an organised strategy.

2.104 The guidelines on which the PRA had to make recommendations were incomplete, particularly with regard to the EPA for which neither effective date nor rate of allowance had been determined. Consequently it felt obliged 'to interpret certain aspects of the guidelines'. The Committee heard that neither the rate set

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66. *Transcript of Evidence* (DHH&CS), 27 November 1991, p. 1012.

67. Health Insurance Commission: *Annual Report 1989-1990*, AGPS, p. 21.

68. *Transcript of Evidence* (PRA), 6 August 1991, pp. 254, 302.

nor the date of effect adopted by the PRA were in keeping with the intended terms of the agreement between the Minister and the Guild.[69]

2.105 A PRA witness stated in evidence that:

> On a number of occasions and in a number of instances, the PRA has expressed dismay that the guidelines it was forced to use allowed for some difficult situations.[70]

It nevertheless unwittingly, through lack of consultation or support, added to these difficult situations.

2.106 The weaknesses and anomalies in the framework of the pharmaceutical restructuring measures which have been highlighted in this chapter did not make the task easy for the people who had to administer provisions and arrangements put together with a minimum of regard to the likely implications. The next chapter of this Report looks at the way in which administrators have handled this situation.

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69. *Transcript of Evidence* (Pharmacy Guild), 23 August 1991, p. 251.

70. *Transcript of Evidence* (PRA), 15 November 1991, p. 881.