The Senate

Community Affairs References Committee

Supply of chemotherapy drugs such as Docetaxel

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Secretariat

Dr Ian Holland (Committee Secretary)

Mr Gerry McInally (Principal Research Officer)

Mr Jarrod Baker (Senior Research Officer)

Ms Eloise Menzies (Research Officer)

Ms Carol Stewart (Administrative Officer)

PO Box 6100
Parliament House
Canberra ACT 2600

Phone: 02 6277 3515
Fax: 02 6277 5829
E-mail: community.affairs.sen@aph.gov.au
Internet: www.aph.gov.au/senate/committee/senate_ca

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43rd Parliament

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Senator Concetta Fierravanti-Wells	New South Wales, LP
Senator Nick Xenophon	South Australia, IND

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Recommendation

3.41 The committee recommends that the government and industry parties, through the review, continue the examination of issues in chemotherapy drug pricing to ensure that existing funds under the Fifth Community Pharmacy Agreement as already agreed are appropriately directed to reflect the costs and benefits of the supply of chemotherapy drugs, and to ensure the ongoing supply of these drugs across all services, particularly in rural and regional areas.

Chapter 1

Introduction

Terms of Reference

1.1 On 7 February 2013 the Senate referred the following matter to the Senate Community Affairs Committee for inquiry and report:

(a) the supply of chemotherapy drugs such as Docetaxel, particularly in relation to:

(i) patient access to treatment,

(ii) cost to pharmacists and suppliers, and

(iii) cost to the private and public hospital systems;

(b) any long-term sustainable funding models for the supply of chemotherapy drugs, including Docetaxel; and

(c) any related matters.[1]

1.2 The reporting date for the inquiry was set by the Senate for 22 April 2013. The committee presented an interim report on that date, indicating that it intended to present its final report by 10 May 2013.

Conduct of the Inquiry

1.3 The committee invited submissions from the Commonwealth Government and interested organisations. The committee received public submissions from 35 organisations and individuals (listed at Appendix 1).

1.4 The committee held one public hearing during the course of the inquiry, in Sydney on 28 March 2013. A list of witnesses who appeared before the committee is set out in Appendix 2.

1.5 Submissions, additional information, the Hansard transcript of evidence and responses to questions on notice can be accessed through the committee's website at: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate_Committees?url=clac_ctte/index.htm. References in this report are to individual submissions as received by the committee, not to a bound volume.

1.6 The committee sincerely thanks all submitters and witnesses for their contribution and participation in the inquiry process.

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1 *Journals of the Senate*, No. 132, 7 February 2013, p. 3596.

Structure of the report

1.7 This report is comprised of 3 Chapters. Chapter 2 provides the background to the inquiry, and an overview of arguments and evidence raised in submissions concerning the supply of cancer drugs such as Docetaxel. Chapter 3 discusses the concerns of witnesses, and the negotiations for the Fifth Community Pharmacy Agreement and implications for the appropriate source of additional funding for the supply of chemotherapy drugs.

Chapter 2

Background to Inquiry

Introduction

2.1 The 76.2% reduction of the weighted average price for Docetaxel, a cancer treatment drug, in the Pharmaceutical Benefits Scheme (PBS) was announced in the second half of 2012. This price cut has been the catalyst for the raising of concerns about wider issues regarding the ongoing costs of supplying chemotherapy drugs to cancer patients.

2.2 This chapter provides a brief description of the broader context in which the inquiry occurred, including:

- the operation of the Pharmaceutical Benefits Scheme
- the Fifth Community Pharmacy Agreement
- Price Disclosure
- current funding arrangements for the supply of chemotherapy drugs under the PBS

Operation of the PBS

2.3 Chemotherapy drugs are supplied to patients in both private and public hospitals in Australia through the PBS, which is 'the primary means through which the Australian Government ensures Australians have timely and affordable access to pharmaceuticals".[1] Under the PBS the Commonwealth subsidises the cost of most medicines for most medical conditions, primarily through reimbursements paid to community or hospital pharmacies.

> When a pharmacist supplies a medicine that attracts an Australian Government benefit, the pharmacist is paid the PBS dispensed price of the medicine, less any patient contribution.
>
> The PBS dispensed price consists of the cost to the pharmacist (the ex-manufacturer price), a mark-up by the pharmacist, dispensing fees, and any other fees the pharmacist is entitled to.[2]

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1 Department of Health and Ageing, *Portfolio Budget Statements 2012-13*, Outcome 2.2, p. 90.

2 The Department of Human Services, *Explanation of PBS Pricing*, http://www.medicareaustralia.gov.au/provider/pbs/pharmacists/pricing.jsp#N1021C (Accessed 3 April 2013). The Department of Human Services also notes that, "The Pharmaceutical Benefits Remuneration Tribunal … implements agreements between the Minister for Health and Ageing … and the Pharmacy Guild of Australia, as to how the PBS dispensed price is to be established (Section 98BAA of the Act)."

2.4 The distinct phases of manufacture, wholesale and dispensing of a particular drug are thus recognised in the calculation of the PBS dispensed price. The Department of Health and Ageing have noted that:

> While the manufacturer is notionally entitled to be paid the ex-manufacturer price for the medicine and the wholesaler is entitled to be paid the full wholesaler margin, competitive pressures mean that these prices may be discounted as a way of winning or maintaining market share. While PBS medicines are ultimately funded by Government and patient co-payments, it is community pharmacies that purchase these medicines from wholesalers or manufacturers and benefit from any discounting that is available.[3]

The Fifth Community Pharmacy Agreement

2.5 Commonwealth remuneration to pharmacies supplying drugs under the PBS is currently governed by the Fifth Community Pharmacy Agreement (5CPA), which was agreed to in 2010, and expires in 2015. As described by the Department, the 5CPA:

> recognises the key role played by community pharmacy in primary health care through the delivery of Pharmaceutical Benefits Scheme (PBS) medicines and related services.[4]

The Pharmacy Guild of Australia notes that:

> Since 1990, the Commonwealth Government and the Pharmacy Guild of Australia have entered into a series of Agreements which set out the remuneration that pharmacists will receive for dispensing PBS medicines and the arrangements regulating the location of pharmacies approved to supply PBS medicines. Over time these Agreements have increased in scope to provide for professional pharmacy programs and services.[5]

2.6 Pharmacy remuneration is one of four main elements covered by the 5CPA, alongside electronic prescriptions, community service obligation arrangements, and programs. Part 2 of the 5CPA:

> constitutes an agreement between the Guild and the Minister as referred to in section 98BAA of the Act which sets out the manner in which the Commonwealth price is to be ascertained and to which the Pharmaceutical

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3 Department of Health and Ageing, *The Impact of PBS Reform – Report to Parliament on the National Health Amendment (Pharmaceutical Benefits Scheme) Act 2007*, 2010, p. 20.

4 Department of Health and Ageing, *Pharmacy and Government Arrangements - Fifth Community Pharmacy Agreement*, 25 July 2012, http://www.health.gov.au/internet/main/publishing.nsf/Content/fifth-community-pharmacy-agreement-copy (Accessed 1 May 2013).

5 The Pharmacy Guild of Australia, *The 5CPA – History of the Agreements*, http://www.5cpa.com.au/sites/5CPA/The_5CPA/History_of_the_Agreements/History%20of%20the%20Agreements.page (Accessed 1 May 2013).

Benefits Remuneration Tribunal must give effect in determining the Commonwealth price.[6]

Clauses 8 to 11 of the 5CPA outline the elements that constitute the dispensed price of drugs supplied through the PBS.

Price Disclosure

2.7 Reforms to the PBS in 2007 introduced a system of price disclosure, which has operated to reduce the dispensed price of PBS medicines that are subject to generic competition on the basis of sales information collected from pharmacies and manufacturers. The 76.2% cut to the dispensed price of Docetaxel was implemented under Expanded and Accelerated Price Disclosure (EAPD). EAPD was introduced in 2010 as an extension to existing price disclosure arrangements, and was agreed to in a Memorandum of Understanding between Medicines Australia and the Commonwealth (the MOU).[7] The MOU was negotiated as part of a wider package of reforms to ensure PBS sustainability. The content of this MOU was known at the time the 5CPA was signed and accommodated within the Agreement. The mechanism underpinning EAPD has remained unchanged since 2010.

Chemotherapy Drugs in the PBS

2.8 Pharmacies supplying chemotherapy drugs are able to recoup both the dispensed price for chemotherapy drugs listed on the PBS, and additional funding that recognises the extra preparation involved in supplying chemotherapy drugs. This second stream of funding is administered under the Revised Arrangements for the Efficient Funding of Chemotherapy Drugs Initiative (EFC) under section 100 of the National Health Act.[8] The government first announced this initiative in the 2008-09 budget. The final form of EFC was based on a proposal – the *Alternative Funding Model for Chemotherapy* – prepared by chemotherapy pharmacy groups and submitted to the Department of Health and Ageing by the Guild during the 5CPA.[9] The EFC covers chemotherapy drugs administered through infusion or injection,

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6 Commonwealth Government & the Pharmacy Guild of Australia, *The Fifth Community Pharmacy Agreement between the Commonwealth of Australia and the Pharmacy Guild of Australia*, May 2010, cl. 7.

7 Commonwealth Government & Medicines Australia, *Memorandum of Understanding*, 6 May 2010, http://www.health.gov.au/internet/main/publishing.nsf/Content/further-PBS-reforms-Agreement (Accessed 3 April 2013).

8 See, the Department of Health and Ageing, *Revised Arrangements for the Efficient Funding of Chemotherapy Drugs & Streamlined Authority Data Capture*, http://www.pbs.gov.au/info/publication/factsheets/shared/revised-arrangements-for-chemotherapy; and Department of Health and Ageing, *Pharmacy and Government Arrangements - Fifth Community Pharmacy Agreement*, http://www.health.gov.au/internet/main/publishing.nsf/Content/fifth-community-pharmacy-agreement (Accessed 8 April 2013).

9 Community Pharmacy Chemotherapy Services Group, *Submission 20*, p. 1, and *Submission 20a*; the Department of Health and Ageing, *Submission 35*, p. 5.

including Docetaxel. Under the EFC, pharmacies can recoup additional fees for the dispensing, preparation, storage, and dilution of chemotherapy drugs. Currently, an in-house pharmacy at a private hospital can recoup $76.37 in fees for each dose of a chemotherapy drug prepared for a patient.

2.9 Pharmacy groups have argued that the amount recouped in fees under the EFC is not sufficient to cover the actual costs of preparing chemotherapy drugs for supply to patients, as the processes involved are highly specialised and complex. Each dose of chemotherapy drugs must be compounded for the individual patient, and this requires the pharmacist to be involved in clinical consultations with patients. As chemotherapy drugs are cytotoxic, community and hospital pharmacies involved in their supply also invest in specialised equipment and facilities to ensure that the drugs are administered in a way that is safe for both the patient and any clinicians involved in preparing and administering the drugs.

2.10 According to pharmacy groups, the extra funding received from Docetaxel payments before the PBS price cut was cross-subsidising the expenses incurred in the preparation of chemotherapy drugs by pharmacies working with private hospitals and clinics. Although other chemotherapy drugs have been subject to price disclosure, the 76.2% price cut for Docetaxel resulted in a $41.5 million reduction in government funding of chemotherapy drugs. This reduction equates to just over 20%, of the savings achieved to date as a result of price disclosure applied to chemotherapy drugs.[10]

10 Pharmacy Guild of Australia, *Submission 25*, p. 20.

Chapter 3

Chemotherapy funding

Concerns raised by Private Providers

3.1 The committee heard concerns from various private providers of chemotherapy services about the sustainability of the current level of funding for the provision of chemotherapy drugs under the PBS. Some private hospitals and cancer clinics considered that increased costs, either as a result of fees imposed by community pharmacies to recoup costs or the reduction in cross-subsidy for in-house chemotherapy preparation, would have the potential to impact on services. UnitingCare Health noted in their submission that:

> The 'collateral damage' of increased costs associated with the supply of chemotherapy treatments will extend to the UCH's ability to invest into staff training, hospitals redevelopment and purchasing the latest technology required to maintain high standards of care delivered to the Australian community. Another indirect impact of a potentially reduced capacity of private hospitals in the provision of chemotherapy services to Australians will be a shift of chemotherapy treatments to the already overloaded public health system.[1]

3.2 During the hearing, Mr Noun, Executive Chairman Northern Cancer Institute, noted that:

> I am also very concerned that these further PBS price reductions will add to the Northern Cancer Institute's already high costs in treating patients with cancer. As I mentioned earlier, we have five pharmaceutical staff supporting our efforts. It is through these additional costs of chemotherapy medication supply that we become very concerned about our ability to continue to provide that service. We are concerned because we would not be able to recover these additional costs from the health funds. In our facility we do not charge the patient for anything. We are contracted straight-out with the health funds or, in the case of the Riverina Cancer Care Centre, we have a contract with New South Wales Health to provide all of those services. Consequently, there is no financial impact to the patient, but that financial impact will flow on to us. Equally, if we try to do that with the health funds, they would not permit these costs. We certainly have tried as things have been changing. We have already made a significant investment in all of our facilities, and I do not consider that it is reasonable for the additional drug funding shortfall to come from places like the Northern Cancer Institute.[2]

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1 UnitingCare Health, *Submission 26*, p 2.

2 Mr Tony Noun, Executive Chairman Northern Cancer Institute, *Committee Hansard*, 28 March 2013, pp. 8–9.

3.3 Dr Robinson, CEO of the Integrated Clinical Oncology Network (ICON) also referred to health fund contracts, noting that:

> ICON cannot find funding solutions from health funds. The department seems to think there are opportunities there. We have contracts that do not allow for that to happen. At this point we are not seeking to charge our patients, and ultimately it is the smaller regional providers that will shut down. Services will contract. Our doctors that are travelling to those regions will not be able to travel there. And those patients will be drawn into the public system or into major tertiary centres.[3]

3.4 The viability of regional and rural chemotherapy services was of particular concern in both the hearing and in submissions received. Submissions from the Clinical Oncological Society of Australia and ICON argued that private clinics established in rural and regional areas on the back of recent government initiatives may now encounter funding difficulties:

> Capital funding for the establishment of 20 regional cancer centres across the country under the Rural Cancer Centres Initiative has the potential to reduce geographic inequity in cancer care outcomes. However, the current federal investment is capital funding only; there is no coordinated intergovernmental plan to underpin the sustainability of these and other regional cancer centres.
>
> A national analysis published by the Clinical Oncological Society of Australia in 2006 showed that the further an individual cancer patient is located from a metropolitan or larger regional hospital, the poorer their access to chemotherapy services. The availability and sustainability of cancer pharmacy services in small regional hospitals in particular is limited, by comparison with larger centres.
>
> If centres in regional and rural locations were forced to close, patients would have to travel substantially further to access chemotherapy or have delayed access to treatment. Any threat to the viability of oncology pharmacy services in remote locations poses a significant threat to patient access to appropriately administered chemotherapy. Compromising access to chemotherapy would risk a further widening in the geographic gap in cancer treatment outcomes.[4]

3.5 During the hearing, Dr Robinson noted that regional providers often have to source doctors and pharmacy services from third parties:

> The challenge will be for us in regional centres where our doctors are travelling to providers where we are not the pharmacy provider, and there are examples in Mackay. We fly doctors into Mackay and they have a very small, five-chair service that is being supported by a local community

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3 Dr Brett Robinson, Chief Executive Officer Integrated Clinical Oncology Network, *Committee Hansard*, 28 March 2013, p. 44.

4 Clinical Oncological Society of Australia and Cancer Pharmacists Group, *Submission 16*, p. 5, and Integrated Clinical Oncology Network, *Submission 19*, p. 9.

> pharmacy. …The regional centres have not got the infrastructure or the capital to build compounding centres. They fly it all in from the third-party providers… They would be the sorts of centres that would go first.[5]

3.6 The committee also received submissions from regional community pharmacies detailing the higher costs of preparing and supplying chemotherapy drugs away from metropolitan centres. Augusta Road Capital Chemist noted that:

> The provision of an adequate service to the population of southern Tasmania comes at a cost. Due to Tasmania's smaller population our facility is relatively small and has high overheads despite careful cost management. Specialist technicians are required to travel from Melbourne to service and validate the facility to National Association of Testing Authorities (NATA) specification. Interstate travel is required for staff training. Relatively small numbers of infusions mean that the average cost per unit is high.[6]

3.7 The Pharmacy Guild also highlighted that:

> in non-metropolitan areas it is more common for the dose (and any associated devices) provided by the third party reconstitution provider to not be used due to a last minute change in dosage or treatment. In this case no reimbursement is available from government and the pharmacy bears the cost. This is particularly common in non-metropolitan areas as the patient may travel 100km (or more) to see their oncologist so for logistical reasons the pre-treatment consultation with the oncologist does not occur until the morning of the scheduled chemotherapy treatment. The dose has been ordered by the community pharmacy from the third party compounder and made available to the hospital or clinic, all costs being borne by the pharmacy, only for the dose to be changed following the morning consultation. The community pharmacy must then re-order the dose (and the infusor if applicable) and has no way of recouping the cost of the dose and infusor that was originally ordered. One community pharmacist, servicing one private hospital and one public hospital in the Albury-Wodonga area, reports that losses as a result of these changes can run to well over $10,000 per year.
>
> Other concerns in more remote areas include the inability to access prepared doses in a timeframe that allows them to be provided to the patient before expiry…
>
> This has been a particular problem in Tasmania. As some drugs cannot be transported from the nearest third party compounder (Melbourne) within the required timeframes to allow patient treatment, community pharmacies in Tasmania have been compelled to invest capital in their own

5 Dr Brett Robinson, Chief Executive Officer Integrated Clinical Oncology Network, *Committee Hansard*, 28 March 2013, p. 45.

6 Augusta Road Capital Chemist, *Submission 29*, p. 1.

> reconstitution facilities to ensure patient access to chemotherapy in the state.[7]

3.8 The committee was made aware of one instance where a pharmacy provider has begun to offset costs in preparing chemotherapy medicines through charging fees to one private hospital to which it supplies chemotherapy drugs. The APHS Pharmacy Group submission notes that it commenced charging an $85 fee per infusion from 1 March, which increased to $100 from 1 April and that:

> Currently the hospital is absorbing this charge, which we understand remains a challenge to the financial metrics of their Cancer Centre. This is a difficult scenario for the hospital and APHS. The St Andrew's Hospital Pharmacy owned by APHS has been a provider of care in the community over many years, and has worked positively with the hospital to be a vital part of the healthcare landscape in the Darling Downs region.[8]

Negotiations concerning chemotherapy funding

3.9 All parties to the inquiry agreed that there is a need for specialised funding arrangements for the supply of chemotherapy drugs. The past existence of a long-running and previously hidden cross-subsidy within Commonwealth pharmaceutical payments was also acknowledged by all parties. In response to concerns about the impact of the price reduction of Docetaxel, the Department has been engaging in fact finding and stakeholder consultation to determine the effect of the reduction in cross-subsidy for cancer medicines on pharmacies, hospitals and consumers since late 2012. As part of this process the Department and the Guild have engaged in 'informal' negotiations 'to work in good faith towards agreeing a cost basis for … chemotherapy funding and a source of funding for any changes.'[9] These discussions have to date not resulted in a resolution of the issue.

3.10 The primary dispute in negotiations between the Department and the Guild appears to concern the potential source of any adjustments to pharmacy funding during the life of the 5CPA. The Guild and other pharmacy groups argued that the EFC was separate from the 5CPA, and that the shortfall in revenue arising as a result of the application of price disclosure to chemotherapy drugs should be made-up from savings achieved through price disclosure.[10]

3.11 The Department did not agree, but identified funds in the 5CPA as the appropriate source of funding:

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7 The Pharmacy Guild of Australia, *Submission 25*, p. 32.

8 APHS Pharmacy Group, *Submission 31*, p. 7.

9 Department of Health and Ageing, *Submission 35*, p. 13.

10 See Pharmacy Guild of Australia, *Submission* 25, pp. 4, 14; Community Pharmacy Chemotherapy Services Group, *Submission 20*, p. 2.

> There have been no suggestions from any stakeholders that the efficiencies generated for taxpayers by the EFC and EAPD measures are inappropriate. As the only other source of available funding, and the structural model for remuneration for pharmacy services, the Fifth Community Pharmacy Agreement has been identified by the Government as the appropriate source for funding chemotherapy fee changes.[11]

3.12 The committee explored the intention behind the 5CPA and contemporaneous agreements to determine whether the 5CPA was the appropriate source of funding for the supply of chemotherapy drugs.

The 5th Community Pharmacy Agreement Negotiations

3.13 The Department maintained that negotiations around the 5CPA, the Efficient Funding of Chemotherapy Arrangements (EFC), and the Memorandum of Understanding between the Commonwealth and Medicines Australia (MOU) were interlinked, that the agreements were contingent upon one another, and that remuneration to pharmacy related to the supply of chemotherapy drugs should sit within funding for the 5CPA.

3.14 The Department pointed out that the initial 2008 reform proposal, the Intravenous Chemotherapy Supply Program (ICSP), was delayed to enable negotiations about remuneration to pharmacists supplying chemotherapy drugs to occur in the context of the 5CPA. In its submission the Department noted that:

> As part of the Fifth Agreement negotiations, the Pharmacy Guild submitted an "Alternative Funding Model for Chemotherapy". During the agreement negotiations the Commonwealth and the Guild agreed on this alternative funding model, and it formed the basis for the new EFC funding model. Details of the new EFC funding were announced in the 2010–11 Federal Budget as part of the Fifth Community Pharmacy Agreement Budget announcement.[12]

3.15 During the hearing the Department drew attention to the Pharmacy Guild 2010 budget brief, which was sent to Guild members in 2010, shortly after negotiations on the agreements had concluded:[13]

> On the front page, the then president, Mr Sclavos, refers to the memorandum of understanding with Medicines Australia and notes that the guild was privy to the details but was not able to give members a running commentary. In the second column, he goes on to talk about how the savings imposed—in other words, price disclosure and so on—would have an impact on community pharmacy but that that was taken into account. If

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11 Department of Health and Ageing, *Submission 35*, p. 14.

12 Department of Health and Ageing, *Submission 35*, p. 5.

13 The Pharmacy Guild of Australia, *Pharmacy Guild 2010 Budget Brief*, 11 May 2010, http://beta.guild.org.au/uploadedfiles/National/Public/Media_Centre/budget_11May2010.pdf (Accessed 17 April 2013).

> you look at paragraph 20 of the actual pharmacy agreement, 'Additional Programs to Support Patient Services', there is an amount of $277 million subsequently injected into a range of clinical services for patients as a consequence of the impact of price disclosure. Further on in the budget update from the guild, there is a reference to funding for chemotherapy medicines:
>
> > These revised arrangements, negotiated and agreed to by the Guild, will deliver a smaller level of savings than the original 2008 Budget measure, but will ensure continued access to these vital medicines.
> >
> > …
> >
> > It is important that Members know that any failure to reach agreement on the chemotherapy savings would have resulted in the general remuneration across community pharmacy being reduced to capture equivalent savings.
>
> That is giving force to the notion that there was a link. There is a single bucket out of which community pharmacy remuneration is paid and negotiated and agreed. Some of it is normal dispensing fees. Some of it is premium free dispensing. And the efficient funding of chemotherapy model was part and parcel of that. So it was all intimately tied up in these things.[14]

3.16 The Department's written submission noted that chemotherapy drugs were funded in the same way as other PBS drugs before the 5CPA:

> Prior to the Fifth Community Pharmacy Agreement, funding for chemotherapy services was provided through a per-script rate, with a dispensing fee ($6.52) paid per script, no different to any other medicine, along with any mark-up on top of the cost of the drug…
>
> The current funding model for chemotherapy drugs was put in place through the EFC measure. This measure was negotiated in the context of three interlinked measures – the Expanded and Accelerated Price Disclosure measure; EFC, and the Fifth Community Pharmacy Agreement (the Agreement).
>
> The current funding model for chemotherapy emerged from the PBS reforms that commenced in 2007 and negotiations between 2009 and 2010 on the measures above.[15]

Links between PBS Sustainability Measures

3.17 In asserting the separation between chemotherapy funding and the 5CPA the Pharmacy Guild claimed there were a number of areas where the EFC and 5CPA could have been linked together, but were not. These included the text of each of the measures themselves, budget announcements, communications and fact sheets around the initial proposal, information documents for each of the arrangements, and

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14 Mr David Learmonth, Deputy Secretary Department of Health and Ageing, *Committee Hansard*, 28 March 2013, p. 31.

15 Department of Health and Ageing, *Submission 35*, p. 5.

legislative instruments supporting the introduction of the EFC, including any Explanatory Memoranda.[16]

3.18 The committee looked to this range of documents for guidance as to the intentions of the parties during the negotiations for the 5CPA and the EFC. These documents showed that the three agreements were negotiated during the same period and were reached under the broad umbrella of ensuring the PBS remains sustainable. The committee also considered that these documents confirmed that there was always a link between the MOU putting in place EAPD and the 5CPA.

3.19 A Departmental fact sheet on the 5CPA noted that:

> The funding provided for Programs will be supplemented by $277 million in recognition of the income forgone by community pharmacies as a result of the *Further Reforms to PBS Pricing* Budget measure. These transitional funds will be used to enhance and support patient services. [17]

3.20 Income forgone by community pharmacies as a result of this budget measure included reductions in price for PBS drugs as a result of Expanded and Accelerated Price Disclosure (EAPD). The *Further Reforms to PBS Pricing* Budget measure consisted of the package implemented under the Memorandum of Understanding with Medicines Australia that introduced EAPD.[18] During a 2010 hearing about the National Health Act (PBS Reform Bills), the Guild recognised that the 5CPA accommodated measures contained in the MOU:

> Mr Armstrong—… The arrangements for the fifth guild-government agreement, or the Fifth Community Pharmacy Agreement, were negotiated in parallel with the arrangements that were negotiated with Medicines Australia. So to some extent the effect (of EAPD) has been able to be taken into account, but of course those agreement negotiations resulted in a billion dollars worth of savings that are in addition to the savings from these reforms.[19]
>
> …The arrangements were negotiated and able to be taken into account in our agreement negotiations. If that were not the case, I do not think we would be supporting the arrangements the way we are. But they were able to be taken into account, so there was a redirection of some funds back into that agreement in recognition of the direct flow-on effect of these changes

16 The Pharmacy Guild of Australia, *Submission 25*, pp. 16–17.

17 Department of Health and Ageing, *Overview of the Fifth Community Pharmacy Agreement*, p. 4 of 7, http://www.health.gov.au/internet/main/publishing.nsf/Content/C3DB799DB360AF0CCA25772000249FA8/$File/5CPA fact sheet.pdf (Accessed 17 April 2013).

18 Department of Health and Ageing, *Portfolio Budget Statements 2010-11*, p. 111.

19 Mr Armstrong, The Pharmacy Guild of Australia, evidence to Senate Community Affairs Legislation Committee, *Inquiry into the National Health Amendment (Pharmaceutical Benefits Scheme) Bill 2010: Official Committee Hansard*, 9 November 2010, p. 13.

> on pharmacy mark-ups, which are directly affected by the formula that makes up the reimbursed price.[20]

3.21 These statements are significant because they showed that the Guild was explicitly stating in 2010 that the effects of Expanded and Accelerated Price Disclosure were taken into account in the 5CPA. These effects include the future price reductions in chemotherapy drugs such as Docetaxel. The budget brief released by the Guild, their statements to the committee during 2010, the text of the 5CPA and the Department's statements pointed to a clear connection between EAPD and the 5CPA.

3.22 The Department maintained that all three measures were interlinked. However, as discussed above, the Guild argued that the absence of any reference to the 5CPA in the announcements for the EFC as evidence that at least these two measures were intended to be separate.[21]

3.23 The media announcement contained on the Department's website for the 5CPA announced the 5CPA and MOU together, but does not refer to the EFC.[22] The Department's Portfolio Budget Statements released in May 2010, however, note that the EFC was negotiated in parallel with these agreements:

> The Australian Government's funding arrangements for the provision of chemotherapy medicines announced in the 2008-09 Budget was deferred from 1 September 2009, to allow consideration of the measure in the context of the negotiations with the Pharmacy Guild of Australia for the Fifth Community Pharmacy Agreement. The measure has been revised in line with a proposal received from community pharmacy and other stakeholders.[23]

3.24 In seeking to demonstrate the absence of concrete links between the 5CPA and the EFC, the Guild argued that:

> The Explanatory Memorandum to the National Health Amendment (Pharmaceutical Benefits Scheme) Bill 2010, which supported the introduction of the new chemotherapy arrangements contained no reference to the 5th Agreement and referred to the arrangements as a budget initiative.[24]

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20 Mr Armstrong, The Pharmacy Guild of Australia, evidence to Senate Community Affairs Legislation Committee, *Inquiry into the National Health Amendment (Pharmaceutical Benefits Scheme) Bill 2010: Official Committee Hansard*, 9 November 2010, p. 16.

21 Pharmacy Guild of Australia, *Submission 25*, pp. 16–17; *Submission 25ss*, 2–6.

22 The Hon Nicola Roxon MP, Minister for Health and Ageing, 'Agreements Ensure Sustainable Access to Medicines', Media Release, 11 May 2010, http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr10-nr-nr094.htm?OpenDocument&yr=2010&mth=05 (Accessed 15 April 2013).

23 Department of Health and Ageing, *Portfolio Budget Statements 2010–11*, p. 111.

24 Pharmacy Guild of Australia, *Submission 25*, pp. 17.

3.25 However, the committee notes that this in incorrect. The Explanatory Memorandum to the National Health Amendment (Pharmaceutical Benefits Scheme) Bill 2010 does refer to the 5CPA and explicitly links the two measures:

> The Bill:
>
> provides a clearer method for listing drugs for supply under section 100 of the Act. This will make clear the application of general PBS provisions such as price disclosure to medicines supplied under those section 100 arrangements;
>
> clarifies and widens the power to make section 100 special arrangements, which will support the introduction of arrangements for the Revised Arrangements for Efficient Funding of Chemotherapy Drugs Budget initiative, and other section 100 programs.[25]
>
> …
>
> The measures set out above are key components of the packages negotiated for Further PBS Pricing Reform, and the Fifth Community Pharmacy Agreement, and miscellaneous amendments related to 2007 PBS Reform.[26]
>
> …
>
> *Revised Arrangements for Efficient Funding of Chemotherapy Drugs*
>
> This measure was announced in the 2008-2009 Budget. Commencement was deferred from 1 September 2009 to allow consideration in the context of negotiations for the Fifth Community Pharmacy Agreement. This Bill does not implement the measure, but makes amendments to section 100 of the Act, and listing arrangements for section 100 medicines, that will support the making of the arrangements for this Program. The measure will now save $75.4 million over the forward estimates period.[27]

3.26 The measures were thus clearly linked in documentation of the time.

Correspondence between the Department and the Pharmacy Guild

3.27 When correspondence between the Guild and the Department recommenced in 2012, the Department's position was consistent with statements made in 2010 around the announcement of the 5CPA, the MOU and the EFC, as well as with its evidence to the current committee inquiry. This is evident in correspondence to the Guild from Mr Learmonth, Deputy Secretary of the Department, on 28 August 2012:

> We appreciate the collaborative and collegiate approach the Guild has taken in working with the Department and with the broader sector to ensure the

25 National Health Act (Pharmaceutical Benefits Scheme) Amendment Bill 2010, *Explanatory Memorandum*, p. 2.

26 National Health Act (Pharmaceutical Benefits Scheme) Amendment Bill 2010, *Explanatory Memorandum* p. 3.

27 National Health Act (Pharmaceutical Benefits Scheme) Amendment Bill 2010, *Explanatory Memorandum*, p. 3.

> successful implementation of the EFC, which commenced on 1 December 2011. As you are aware, the EFC was based largely on the proposal received from the Guild as part of the Fifth Community Pharmacy Agreement negotiations (Fifth Agreement) between the Guild and the Australian Government, signed in May 2010.

3.28 The same policy position is demonstrated in correspondence from Hon Tanya Plibersek MP, Minister for Health, on 22 October 2012:

> Whilst I note your concerns, I also note that Pharmaceutical Benefits Scheme Pricing Reforms, including Expanded and Accelerated Price Disclosure, the Efficient Funding of Chemotherapy (EFC) measure and the Fifth Community Pharmacy Agreement were negotiated concurrently, which allowed all parties to consider the overall impact of all these factors on pharmacy remuneration. I also note that the model for EFC adopted was based largely on your proposal.

3.29 In their supplementary submission, the Guild claimed that the Department had, in the days prior to the signing of the 5CPA, written to them, confirming that there was no connection between the EFC and the 5CPA:

> a matter of days prior the public announcement of the 5th Community Pharmacy Agreement, the Department confirmed in writing that the EFC model had been agreed and was separate from the Agreement.[28]

3.30 In response to a request from the committee, the Guild and the Department both supplied an email that was the basis for the point made by the Guild. Under the subject heading, 'Chemotherapy program in context of 5CPA', a Departmental officer had written:

> I can advise that the revisions to the Chemotherapy program including modifications to the forward estimates, as agreed between the Department and the Guild, has been accepted by Government.
>
> This is (sic) measure remains separate from the Fifth Agreement.[29]

3.31 In a letter to the committee accompanying the above correspondence, the Department provided the following context:

> the Guild had proposed a new mechanism to fund chemotherapy services. The agreement about 5CPA funding included a provision that the Guild's proposal for chemotherapy funding would be properly developed, and that if it turned out to save less than had been proposed, then the difference would be made up by further cuts to general pharmacy remuneration.
>
> After this 2009 agreement, and before the 5CPA was finalised in May 2010, further work on the Guild's chemotherapy proposal showed that it would, in fact, save the amount of money that was claimed.

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28 The Pharmacy Guild of Australia, *Submission 25ss*, pp. 3 and 5.

29 The Department of Health and Ageing, Letter to Dr Ian Holland, Secretary Senate Community Affairs Committee, 29 April 2013.

> My email simply advised the Guild of this, and that the Government's budget forward estimates would be amended accordingly. As the claimed saving had been achieved, there was no need to make any further cut to pharmacy remuneration under the 5CPA, which could then be finalised.[30]

3.32 In this context, rather than suggesting that the matters were unrelated, the text indicates that the agreement on chemotherapy funding had been contingent on 5CPA remuneration being available to achieve the desired savings. The text suggests that the agreements are separate documents, not that the matters are unrelated. This is evident also from the email's subject line, and is underlined by the interchange, in the same email thread, between two Guild officials:

> have just received this email from [Departmental official] re Chemo. It is all accepted as the model we put to them in feb.

3.33 This interchange reinforces that the negotiations across the various aspects of pharmaceutical policy were interlinked, and that all the parties knew that the outcomes were conditional on all aspects being agreed.

3.34 The committee considers that the links established between the MOU and the 5CPA, and the references to the 5CPA in the May 2010 Portfolio Budget Statements and the explanatory memorandum for the legislation supporting the introduction of the EFC, corroborated the Department's position that the three measures were always understood to be interlinked.

Committee View

3.35 The committee recognises that the supply of chemotherapy drugs to cancer patients is a complex and intensive exercise, requiring specialised skill and effort on behalf of oncology pharmacists. The committee notes that stakeholders in this inquiry do not dispute the need for adequate funding of these services. That chemotherapy services have to date been funded through long-running, hidden cross-subsidies is similarly agreed to by all parties involved.

3.36 This is not a new issue. These concerns were identified several years ago, prior to the signing of the 5CPA, and it was the Guild that put forward a proposal to address this matter, including price modelling that was accepted by the government at the time. The crux of the current inquiry therefore lay in determining the appropriate source of remuneration to pharmacists to reflect the costs of preparing and supplying chemotherapy infusions.

3.37 It is clear from the committee's evidence that the negotiations and finalisation of the 5CPA took place in the context of PBS sustainability reforms, including the EFC and EAPD measures. The modelling used to determine the costs to pharmacists of preparing chemotherapy drugs was prepared by the Guild in the context of the

30 The Department of Health and Ageing, Letter to Dr Ian Holland, Secretary Senate Community Affairs Committee, 29 April 2013.

5CPA negotiations and EAPD. This modelling was provided to the Department by the Guild in the course of the 5CPA negotiations. The government accepted this modelling, and the costs of supplying chemotherapy drugs, as reflected in the fees contained in the EFC, were part of the known environment in which the 5CPA was agreed. That this was understood by both negotiating parties is made explicitly clear by the Guild's statement to its members at the time that:

> It is important that Members know that any failure to reach agreement on the chemotherapy savings would have resulted in the general remuneration across community pharmacy being reduced to capture equivalent savings.[31]

3.38 The committee considers that the Department's position that funding should occur within the envelope of the 5CPA is consistent with documents from the time, and continues a position that the government has maintained throughout the process. Having reviewed statements provided to the committee by the Guild and the Department, and the statements made by both parties in 2010, the committee accepts that the three measures implemented in 2010 were intended to be linked. The committee recommends the Department and the Guild continue in their negotiations to resolve the funding issue.

3.39 In this regard, the committee notes that, shortly before the committee was due to table this report, the Minister announced a review to determine the correct subsidy for chemotherapy infusions. The review will 'identify options for a long term and sustainable funding model that identifies and appropriately manages all components of chemotherapy dispensing and supply and is not dependent on the cross-subsidisation from the price of chemotherapy medicines for the viability of chemotherapy services', and will report to the Minister for Health by October 2013.[32]

3.40 In addition, the government announced that the May budget will include an additional $29.7 million 'to pay providers an additional $60 for each chemotherapy infusion on an interim basis for six months' between July and December 2013.[33]

Recommendation

3.41 The committee recommends that the government and industry parties, through the review, continue the examination of issues in chemotherapy drug pricing to ensure that existing funds under the Fifth Community Pharmacy Agreement as already agreed are appropriately directed to reflect the costs and

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31 The Pharmacy Guild of Australia, *Pharmacy Guild 2010 Budget Brief*, 11 May 2010, p. 4 of 7, http://beta.guild.org.au/uploadedfiles/National/Public/Media_Centre/budget_11May2010.pdf (Accessed 17 April 2013).

32 Department of Health and Ageing, *Pharmacy, PBS Chemotherapy Medicines Review*, http://www.health.gov.au/chemo-review (Accessed 7 May 2013).

33 The Hon Tanya Plibersek, 'Review to determine correct subsidy for chemotherapy infusions', *Media Release*, 5 May 2013.

benefits of the supply of chemotherapy drugs, and to ensure the ongoing supply of these drugs across all services, particularly in rural and regional areas.

Senator Rachel Siewert

Chair

Coalition Senators' Additional comments

1.1 The Government's failure to properly fund the delivery of chemotherapy services to Australia's cancer sufferers and support to their families has been described as not simply a matter of arguing the removal of a subsidy for the cancer drug Docetaxel, but as a "failure to complete a government initiated reform" to chemotherapy funding agreed in 2009.[1]

1.2 The Government's failure to have satisfactorily resolved this issue earlier is a demonstration of its policy ineptitude and laziness. According to evidence of many witnesses, this lack of a timely resolution may put at risk affordable and quality of care and access to treatment for cancer patients

1.3 The evidence on these points was clear and near unanimous.

1.4 The Clinical Oncology Society of Australia said:

> If there is no longer an income stream to maintain the clinical pharmacy services associated with the supply of chemotherapy, this is likely to affect the cost of care and patient access. Centres will close or pass on the additional costs to patients in order to remain viable.[2]

1.5 It added that cancer patients could find themselves "being forced onto potentially long waiting lists in the public health system".[3]

1.6 The Pharmacy Guild of Australia said:

> Ongoing care for all Australian cancer patients, regardless of their type of cancer, is being put at risk by the current arrangements.[4]

1.7 The largest provider of private day oncology services on the North Shore and northwest Sydney, the Sydney Adventist Hospital, said the funding approach could lead to "cessation of all chemotherapy infusions, provision of a limited range of treatments and pharmacy staff reductions".[5]

1.8 The evidence from providers and specialists in chemotherapy all stressed the critical need for effective funding arrangements given the unique characteristics and high quality care needed to dispense treatment to cancer patients:

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1 Medical Oncology Group of Australia Inc. and Private Cancer Physicians of Australia, *Submission 17,* p. 2.

2 Clinical Oncological Society of Australia and Cancer Pharmacists Group, *Submission 16,* p. 3.

3 Clinical Oncological Society of Australia and Cancer Pharmacists Group, *Submission 16,* p. 3.

4 The Pharmacy Guild of Australia, *Submission 25*, p. 4.

5 Sydney Adventist Hospital, Adventist Healthcare, *Submission 15*, p. 2.

> The service of preparing chemotherapy medication is highly complex, expensive and labour-intensive, and demands an environment and investment that does not compromise on quality.[6]

1.9 A clear conclusion from the evidence was that the current chemotherapy funding model does not provide adequate financial recognition of the actual costs incurred providing chemotherapy infusions in the oncology service, and is not a transparent or sustainable funding model.

1.10 The MOGA written submission reflected the comments of many other professionals to the inquiry when it said "the current remuneration model for chemotherapy does not reflect how contemporary cancer services are delivered".[7]

A further delay on delivering funding certainty

1.11 The Government's announcement on 5 May 2013 that it would initiate a funding review into chemotherapy and provide $29.7 million in the 2013/2014 Budget to provide an additional $60 for each chemotherapy infusion for only six months is an admission that is has failed cancer sufferers and their families.[8]

1.12 The latest review follows a previous commitment given six months prior to this latest announcement to examine the "cost of delivering vital chemotherapy services".

1.13 The latest announcement prolongs uncertainty and undermines the effective and efficient delivery of treatments for cancer patients and their families. It points to a lack of appreciation for the critical implications being felt by chemotherapy services as a result of the PBS price reductions applied on 1 December 2012 and again on 1 April 2013.

1.14 Despite the announcement, the Government is still unable to detail for providers of chemotherapy services and their patients any definitive long-term funding solution.

Appropriateness of price disclosure

1.15 Contrary to the suggestion made by the Consumers Health Forum in its written submission, the appropriateness of price disclosure policy used by Government to fund access to medications is not in dispute.

1.16 The Committee heard from various witnesses about the appropriateness of price disclosure and its role in providing improved access to medications in Australia's health system.

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6 Slade Pharmacy Services, *Submission 9*, p. 2.

7 Medical Oncology Group of Australia Inc. and Private Cancer Physicians of Australia, *Submission 17*, p. 4.

8 Hon Tanya Plibersek MP, Minister for Health, 'Review to Determine Correct Subsidy for Chemotherapy Infusions', Media Release, 5 May 2013.

1.17 The Pharmacy Guild of Australia said it "recognises that price disclosure is an appropriate mechanism for taxpayers to share in the price benefits of competition in the off-patent medicines market" and that it is "delivering significant savings".[9]

1.18 Coalition Senators believe the critical issue is not price disclosure, but remuneration arrangements that reflect the particular and unique nature of dispensing chemotherapy treatments. This may have been poorly appreciated by the Consumer Health Forum.

Poor understanding of significance of cross subsidisation in delivery of private chemotherapy services

1.19 More than 50% of all cancer care in Australia is provided in the private health sector and more than 13,000 life saving infusions are prepared and dispensed by community and private hospital pharmacies for cancer patients each week.

1.20 Coalition Senators believe the success of delivering quality chemotherapy services in Australia is the direct result of a health system that incorporates both private and public provision of chemotherapy services.

1.21 At the heart of the Government's policy failure is their lack of proper appreciation and regard for the heavy reliance of private chemotherapy services on the PBS margin on Docetaxel to cross subsidise the costs of providing a clinical pharmacy service to cancer patients.

1.22 This view was expressed by the Clinical Oncology Society of Australia and the Cancer Pharmacists Group.

> For many years pharmacies have been using the reimbursement price of medicines such as Docetaxel to fund other loss making chemotherapy medicines and the provision of vital clinical pharmacy services to ensure the safety of cancer patients.[10]

1.23 The existence of the cross subsidisation and its role in funding world class cancer treatment in Australia is a well-known practice with a long history.

> Pharmacies and private hospitals have been reliant on the trading terms of medicines such as Docetaxel and revenue generated to fund other medicines and other pharmacy services including clinical pharmacy services for over two decades.[11]

1.24 While many witnesses agreed the cross subsidisation of services was "inappropriate", the point was made that in the absence of any identifiable alternative income stream, this approach had "ensured the safe supply of chemotherapy services to patients with cancer".

1.25 Coalition Senators believe the Government has failed in its primary responsibility to develop a more transparent and sustainable funding model that

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9 *Committee Hansard*, 28 March 2013, p. 6.

10 Clinical Oncological Society of Australia and Cancer Pharmacists Group, *Submission 16*, p. 7.

11 Cabrini, *Submission 3*, p. 3.

reduces the reliance on cross subsidisation by ensuring price disclosure is accompanied by a parallel remuneration structure reflecting the real costs of delivering cancer treatments.

Impact on access to cancer treatment for Australians living in regional areas

1.26 The Government's approach is most alarming for its repercussions for regional and rural Australians.

1.27 Evidence provided to the Committee by the Clinical Oncology Society of Australia specifically addressed the adverse health outcome experience by cancer patients living outside Australia's capital cities.

> Evidence shows that the further a cancer patient lives from a metropolitan centre, the more likely they are to die within five years of a diagnosis. For some cancers, remote patients are up to 300% more likely to die within five years of diagnosis. Cancer care is less accessible as geographic isolation increases, with survival rates correlating directly to quality and availability of services.[12]

1.28 The Committee heard from a variety of providers about the significant and early adverse impact that would be inflicted upon cancer patients living in regional and rural areas of Australia.

1.29 The MOGA made the point strongly in its evidence.

> It is the belief of our Association that rural services will be the first to feel the adverse impacts of the inadequate reimbursement of chemotherapy services. This is particularly disturbing given that this was previously identified as an area of need with inferior survival and quality of life outcomes.[13]

1.30 The Clinical Oncological Society of Australian and the Cancer Pharmacists Group echoed these sentiments:

> If centres in regional and rural locations were forced to close, patients would have to travel substantially further to access chemotherapy or have delayed access to treatment.[14]

and

> The viability of chemotherapy services provided by the private sector including those at centrally funded rural chemotherapy treatment centres, is at risk following the reduction in the reimbursement price of Docetaxel.[15]

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12 Clinical Oncological Society of Australia and Cancer Pharmacists Group, *Submission 16*, p. 5.

13 Medical Oncology Group of Australia Inc. and Private Cancer Physicians of Australia, *Submission 17*, p. 5.

14 Clinical Oncological Society of Australia and Cancer Pharmacists Group, *Submission 16*, p. 5.

15 Clinical Oncological Society of Australia and Cancer Pharmacists Group, *Submission 16*, p. 7.

1.31 Concerns about the provision of chemotherapy services in regional Australia were reflected in the evidence from Cancer Voices.

> The main problem is in rural areas where there may not be a public service and there may be a small medical oncology service which provides chemotherapy. That is an area of particular concern, yes.[16]

1.32 Dr Christopher Steer of Border Medical Oncology, a private practice operating in Wodonga, provided evidence on how the provision of chemotherapy services in regional Australia differed from treatments provided in the metropolitan area.

1.33 It identified a number of adverse consequences for regional Australians from the failure to properly fund chemotherapy services.

> Regional and rural hospitals are more vulnerable to the problems in this program due to their relatively small patient base and inability to cover costs from other profitable areas

and

> There does not seem to be a recognition that safe and appropriate delivery of chemotherapy requires more infrastructure, time and skill and thus costs more than a routine prescription. This is a particularly evident in rural and regional areas where a community pharmacist often delivers this service in the absence of a public hospital pharmacist.[17]

1.34 Dr Steer's concluded his written evidence with the observation that "we are already told patients in rural areas fare poorly when compared with their city cousins; we don't need yet another set back".

Abuse of good faith

1.35 It is unfortunate the Government's lack of resolve on this issue has tested the good faith and patience that chemotherapy providers have shown in seeking a satisfactory, longer-term funding solution.

1.36 The net effect of the Government's delay has been to force many private chemotherapy providers to absorb the high costs of delivering personally-tailored and safe chemotherapy treatments to cancer patients.

1.37 The costs that providers have had to absorb are significant. The Sydney Adventist Hospital Pharmacy estimated a $1.6 million financial shortfall as a result of changes to the PBS since April 2010.

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16 *Committee Hansard*, 28 March 2013, p. 4.

17 Dr Christopher Steer, 'A regional perspective', tabled by APHS Pharmacy Group, 28 March 2013.

The appropriateness of advocacy by providers and other health professionals

1.38 Coalition Senators believe providers of chemotherapy services have acted responsibly in finding an appropriate balance between raising their concerns and objections to the Government's approach to this matter with the need for cancer patients and their families to be spared unnecessary anxiety about the provision and affordability of their current and future treatments.

In Summary

1.39 Coalition Senators believe the Government has been irresponsible in not addressing the concerns of providers of chemotherapy treatments especially given that their concerns are well known to the Government.

1.40 Coalition Senators also believe it is totally reasonable that because of the special and intensive nature of administering chemotherapy treatment, attention should be given to other remuneration streams to ensure these treatments are administered in a safe and highly effective way.

1.41 In addition, Coalition Senators also believe that the existence of both public and private providers of these treatments is particularly important in ensuring that Australians in rural and regional areas have proper access.

1.42 Coalition Senators believe the Government has taken too limited a view regarding consultations associated with the Fifth Community Pharmacy Agreement and in particular chemotherapy funding. While the difference of opinion has focused largely on community pharmacy, the issue of chemotherapy funding has significant implications for providers not directly involved in the pharmacy agreement. On this basis, the Government should ensure its future consultations are more inclusive of other interested parties.

Senator Dean Smith **Senator Sue Boyce**

Additional comments by Senator Nick Xenophon

1.1 I am one of the instigators of this inquiry following numerous representations made by cancer treatment providers (including the community pharmacy sector) and cancer patients. There is no question that increased price transparency of chemotherapy drugs is a laudable public policy position. However, the apparently unintended consequences of reducing the price paid for the supply of some chemotherapy drugs have been significant and detrimental to providers, with widespread potential impacts on patients. Unless the impasse can be resolved soon there is very real risk that many Australians requiring chemotherapy treatment will be significantly disadvantaged, and in some cases, health outcomes compromised. The reduction in the price paid for the supply of some chemotherapy drugs, in some cases by more than 70 per cent, sent a wave of concern through many cancer treatment providers and patients.

1.2 The announcement by the Health Minister on 5 May 2013 that there will be an inquiry into the issues canvassed by this Senate inquiry should be seen as a belated acknowledgement by the Government of the seriousness of this problem. To that end this Senate committee inquiry should reasonably be seen as a catalyst for the Government's recent announcement.

1.3 Unless the issues raised by this inquiry are resolved there could be widespread closure of chemotherapy services to cancer patients in the private sector, with a consequence that the public sector will be overwhelmed by additional demand. In regional areas this may also mean patients will be put to the inconvenience of having to travel many kilometres to receive treatment. There is a broader concern that, given the time critical nature of chemotherapy treatment, the treatment of patients could be compromised.

Impact on patients

1.4 The ability of the public sector to cope should private providers be forced out of the market due to the price cuts to chemotherapy drugs was a real concern among many witnesses:

> If the current system for the preparation and supply of chemotherapy drugs through private hospitals and private clinics collapses, cancer patients are likely to be forced into the already overstretched public hospital system. The public hospital system does not have the capacity to deal with closures of cancer clinics in the private sector. Put simply: it will not cope. In centres in regional and rural locations, if they were forced to close, patients would have to travel substantially further to access chemotherapy or have delayed access to treatment. We know that country patients want to be treated in the country. They do not want to travel three hours to the nearest metropolitan centre. Any threat to the viability of oncology pharmacy services in remote

> locations poses a significant threat to patient access to appropriately administered chemotherapy.[1]

1.5 Mr Wayne Pertzel should be congratulated for his courage in giving evidence to the committee in relation to the chemotherapy his wife Mandy is receiving. He described for the committee what impact changing from a private chemotherapy provider (through which his wife could schedule appointments for treatment) to the public system would have on his family:

> You talk about the impacts of the funding on the patients themselves. As a carer, I can say that the impact on us is that I have to get the patient—Mandy—a significantly greater distance to get the care. On top of that, I then have to wait around for significantly longer while the patient gets the care.[2]

1.6 Mr Pertzel continued:

> The ability to have the care locally means so much to the patients. It is staggering how much that means. I do not think anyone would believe that you would get a different level of care in a public hospital or a private hospital, but public hospitals are not everywhere and private hospitals do fill a lot of those gaps. From someone who is living with it, it is very important to us.[3]

1.7 The importance of access to cancer treatment, particularly for patients in rural and regional areas cannot be underestimated:

> We know based on evidence that, as the distance increases from where the service is available, the type of service and those receiving optimal service are reduced. Utilisation rates change. For example, in radiotherapy they go from 52.6 per cent down to as little as 25 per cent, and then they opt for mutilating surgical procedures. They do all sorts of weird and crazy things, and in fact the overall cost to the public purse, I believe, is substantially more than the cost of providing the services and being able to fund them appropriately.[4]

1.8 Given the demonstrated barriers of access to cancer treatment faced by patients in rural and regional Australia, it is vital that all providers, but particularly those located in these areas are compensated appropriately for the delivery of cancer treatment. That in a developed country such as our own cancer sufferers are continuing to forego treatment due to logistical difficulties is completely unacceptable.

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1 Mr Dan Mellor, *Committee Hansard*, 28 March 2013, p. 7.

2 Mr Wayne Pertzel, *Committee Hansard*, 28 March 2013, p. 22.

3 Mr Wayne Pertzel, *Committee Hansard*, 28 March 2013, p. 23

4 Mr Noun, *Committee Hansard*, 28 March 2013, p. 16.

Funding arrangements for chemotherapy drugs

1.9 I have little doubt this inquiry played a strong role in bringing about the Federal Government's announcement on 5 May 2013 that a one-off funding boost of $30 million will be provided for chemotherapy drugs. This has provided some relief for providers and patients, however it is clear this is just a stop-gap solution to a serious ongoing problem. I urge the Federal Government to consult with the industry in order to develop an efficient funding model for the delivery of chemotherapy drugs.

1.10 As has been made clear by submissions and evidence given to this inquiry, the supply of chemotherapy drugs in Australia has been funded by an inefficient and unsustainable model for too long. For example, one submitter to the inquiry stated:

> For years, higher margins for some items dispensed through the PBS (such as Docetaxel) have:
>
> – offset (cross subsidised) the cost of compounding the majority of chemotherapy medicines where the financial cost of supply far exceeds the return via the PBS.
>
> – offset (cross subsidised) the delivery of clinical services and administration related to the PBS.
>
> For years, this is the business model our organisation, and others, have used to provide clinical, administrative and compounding services, primarily due to the inadequate funding required to deliver high quality, best practice health care.[5]

1.11 The submitter continued:

> To ensure equitable access to suitable medicines that are safe and effective (National Medicines Policy) and avoiding a 'user pays' system developing, it is a requirement of governments to ensure that healthcare providers can deliver these outcomes cost effectively. However, without appropriate and transparent reimbursement, these objectives are not achievable. As pharmacists, we are in support of cuts to the price of PBS medicines. We agree taxpayers should not be paying unnecessary high prices for generic medicines, especially as more high-cost drugs come off patent.
>
> Current funding for supply of chemotherapy AND associated clinical services is inadequate. I would like to see a funding model that compensates compounding pharmacies for the true costs of compounding these products and providing clinical pharmacy services to these patients.[6]

1.12 Support for transparency was strong among the industry. For example, Ms Carol Bennett, Chief Executive Officer of Consumers Health Forum Australia told the committee:

> CHF supports transparency and sustainability in funding arrangements for all health services. This is why we strongly support the price disclosure

5 Name Withheld, *Submission 30*, p. 5.

6 Name Withheld, *Submission 30*, p. 5

> policy, which brings government expenditure on Pharmaceutical Benefit Scheme medications in line with the market prices for these medications being paid by pharmacies.[7]

1.13 The Federal Government must ensure transparency is a key element of the new funding model that will result from the current inquiry into the supply of chemotherapy drugs. This is achievable by audits being conducted on the new funding model every three years by the Australian National Audit Office.

Recommendation: The Australian National Audit Office conduct an audit of the funding model for the supply of chemotherapy drugs every three years.

Government consultation

1.14 The committee has thoroughly examined the history of Commonwealth Government funding for chemotherapy drugs by way of the Pharmaceutical Benefits Scheme ('PBS') and has concluded the Department of Health and Ageing has been consistent in their approach in that funding for chemotherapy drugs was always a part of the Fifth Community Pharmacy Funding Agreement. However it should be noted that while funding negotiations between the Department and the Pharmacy Guild have been ongoing for a number of years, they have not necessarily been industry inclusive:

> Senator MOORE: My understanding of the process is that none of you are around the negotiation table on this issue. That is right isn't it?
>
> Dr Bashford: That is correct.
>
> Senator MOORE: So you all accept that this negotiation continues between the Pharmacy Guild and the department.
>
> Dr Clark: That is correct.
>
> Senator MOORE: I am worried by that.
>
> Dr Clark: … The minister has completely shut them – I am speaking on behalf of the Australian Private Hospitals Association – out of the discussions, to my knowledge.[8]

1.15 Dr Clark continued:

> I guess we feel as though we have been shut out. That breeds a degree of suspicion. It may not be warranted. But I think it is fair to say that private for-profit and not-for-profit organisations involved in this very important aspect of the treatment of cancer patients feel that this is extremely unfair and they are accepting the burden here, which really puts them in a very difficult situation. We are interested in giving the patients the best possible care, and we are being put in a situation whereby financially it becomes unviable. Some people can accept those losses and some cannot. We are not as vulnerable as some, but we are talking about across the board here, not

7 Ms Carol Bennett, *Committee Hansard*, 28 March 2013, p. 37.

8 Dr John Bashford and Dr Leon Clark, *Committee Hansard*, 28 March 2013, p. 46.

> just ourselves, because patients go to a variety of providers outside the public sector. So I guess it is an expression of anger and frustration.[9]

1.16 It is unclear why the Department would exclude major stakeholders such as the Australian Private Hospitals Association from negotiations about funding for the supply of vital chemotherapy drugs. Therefore the Department should consult with a broader range of parties during the new review of chemotherapy funding arrangements.

1.17 The implementation of the Federal Government's price transparency regime for chemotherapy drugs has had a number of apparently unintended consequences that are serious and must be urgently addressed. The Government has been warned of the impending problems for some time, and the announcement on the 5th of May 2013 is a belated acknowledgement of the severity of the problem. It is critical, for the sake of cancer patients requiring chemotherapy across Australia, that this crisis is resolved as a matter of urgency.

Senator Nick Xenophon

9 Dr Leon Clark, *Committee Hansard*, 28 March 2013, p. 47.

APPENDIX 1

Submissions and Additional Information received by the Committee

Submissions

1	Name Withheld
2	Think Pharmacy Oxley
3	Cabrini
4	The Wesley Pharmacy Group
5	Sunshine Coast Haematology and Oncology Clinic
6	The Society of Hospital Pharmacists of Australia
7	Northern Cancer Institute
8	Epworth HealthCare
9	Slade Pharmacy Services
10	Joondalup Hospital Pharmacy
11	Confidential
12	Department of Health and Human Services Tasmania
13	Pharmaceutical Society of Western Australia
14	CanSpeak
15	Sydney Adventist Hospital, Adventist HealthCare
16	Clinical Oncological Society of Australia and Cancer Pharmacists Group
17	Medical Oncology Group of Australia Inc. and Private Cancer Physicians of Australia
18	Cancer Voices Australia
19	Integrated Clinical Oncology Network (ICON)

20 Community Pharmacy Chemotherapy Services Group

21 Mr John Jackson

22 Consumers Health Forum of Australia

23 Ramsay Pharmacy Services

24 Australian Private Hospitals Assocation

25 The Pharmacy Guild of Australia

26 UnitingCare Health

27 Medicines Australia

28 Confidential

29 Capital Chemist

30 Name Withheld

31 APHS Pharmacy Group

32 Pharmaceutical Society of Australia Ltd

33 Catholic Health Australia

34 Confidential

35 Department of Health and Ageing

36 South Australian Government

37 Confidential

Additional Information

1 Tabled document from Society of Hospital Pharmacists of Australia, at Sydney public hearing 28 March 2013

2 Tabled document from Slade Pharmacy Services, at Sydney public hearing 28 March 2013

3 Tabled document from APHS Pharmacy Group, at Sydney public hearing 28 March 2013

4 Tabled document from Northern Cancer Institute, at Sydney public hearing 28 March 2013

5 Tabled document from Northern Cancer Institute, at Sydney public hearing 28 March 2013

6 Tabled document from Northern Cancer Institute, at Sydney public hearing 28 March 2013

7 Tabled document from Northern Cancer Institute, at Sydney public hearing 28 March 2013

8 Tabled document from Northern Cancer Institute, at Sydney public hearing 28 March 2013

9 Research paper presentation, from APHS Pharmacy Group, received 12 April 2013

10 Sustainable funding model, from Society of Hospital Pharmacists of Australia, received 11 April 2013

Correspondence

1 Correction from Society of Hospital Pharmacists of Australia to evidence given at Sydney public hearing 28 March 2013

2 Correspondence from SA Health, received 4 April 2013

Answers to Questions on Notice

1 Answers to Questions on Notice received from Northern Cancer Institute, 2 April 2013

2 Answers to Questions on Notice received from Clinical Oncological Society of Australia, 3 April 2013

3 Answers to Questions on Notice received from CanSpeak, 8 April 2013

4 Answers to Questions on Notice received from Sydney Adventist Hospital, 8 April 2013

APPENDIX 2

Public Hearings

Thursday, 28 March 2013

Cliftons Sydney, 60 Margaret St, Sydney

Witnesses
Cancer Voices Australia
CROSSING, Ms Sally, Spokesperson

Pharmacy Guild of Australia
ARMSTRONG, Mr Stephen, National Manager, Economic Analysis and eHealth
QUILTY, Mr David, Executive Director
WILSON, Mr Adrian, member, and Managing Partner, McBeath Pharmacies

Clinical Oncology Society of Australia
MELLOR, Mr Dan, Chair of the COSA Cancer Pharmacists Group

Northern Cancer Institute
NOUN, Mr Tony, Executive Chairman
CUMMINS, Mrs Meredith, Director of Nursing

Society of Hospital Pharmacists in Australia
KIRSA, Mrs Suzanne, President
DOWLING, Mrs Helen, Chief Executive Officer

Slade Pharmacy Services
SLADE, Mr David, Managing Director

Private Capacity
PERTZEL, Mr Wayne

APHS Pharmacy Group
GILES, Mr Stuart Anthony, Managing Partner and Executive Chairman

Department of Health and Ageing
LEARMONTH, Mr David, Deputy Secretary
MCNEILL, Ms Felicity, First Assistant Secretary, Pharmaceutical Benefits Division

Consumers Health Forum of Australia
BENNETT, Ms Carol, Chief Executive Officer

Integrated Clinical Oncology Network Cancer Care Board
ROBINSON, Dr Brett, Managing Director and Chief Executive Officer

Private Cancer Physicians of Australia and Medical Oncology Group Australia
BASHFORD, Dr John

Sydney Adventist Hospital – Pharmacy Services
CLARK, Dr Leon, Group Chief Executive Officer
DUFFY, Mrs Margaret, Pharmacy/Corporate Services Executive Officer

CanSpeak

STUBBS, Mr John, Chief Executive Officer